Stanford HEALTH CARE
STANFORD MEDICINE

Anatomic Pathology and Clinical Laboratories
Customer Service Toll Free (877) 717-3733

Cytogenetics (Heme/Oncology)

For Lab Use Only	Facility Name	Ordering Physician Name Last First
	Address	Physician NPI No.
	City, State, Zip	Physician Phone No. ( )
	Facility Phone Number ( )	Report Fax Number ( )

Patient Name (Last) (First)				Insurance Info: Attach a copy of front & back of Insurance card or face sheet ☐Private Ins/PPO ☐ Medicare ☐ Medi-Cal ☐ Patient ☐Client
Submitter ID Unique ID or MRN		DOB-Required	Sex M F	Responsible Party (Please Print)
Patient's Phone Number ( )	Collection Date & Time	Collection by- Required		Address
Copy to: First Name	Last Name			City, State, Zip
Copy to complete address for mailing:				**ICD Code(s) - *REQUIRED INFORMATION*** Physician Signature: Date: Time:

Each individual test and CMS approved panel must have ICD code(s) to indicate the medical necessity of the test requested. Please provide all applicable ICD code(s) for the tests ordered. @ Tests for Medicare Patients Must be screened to determine if an Advanced Beneficiary Notice (ABN) is required. An ABN must be provided to the Medicare patient if there is a reason to believe Medicare will deny the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests. *Continued on page 2.*

SAMPLE TYPE *(REQUIRED)*

☐Peripheral Blood ☐ Fluid; type _____

☐Bone Marrow Aspirate

☐Core Biopsy, Bone Marrow

☐Fresh Tissue; site _____ Type _____

Clinical History:

Check Suspected Diagnosis

Acute Leukemia

☐AML type: _____

☐ALL type:_____

Lymphoproliferative Ds.

☐Lymphoma Type:_____

☐CLL

☐ Myeloma

☐Other:_____

Myelodysplastic Syndrome

☐Refractory Anemia
☐excess blasts? ☐ transformation?

☐CMML

Myeloproliferative Disorder

☐CML

☐ Polycythemia Vera

☐ Thrombocythemia

☐ Myelofibrosis

BMT/Therapy Status

Recent Chemotherapy? ☐No ☐Yes; Date_____

Status Post Transplant? ☐No ☐Yes; Date_____

Transplant Type? ☐ Auto ☐Allo

Donor Sex: ☐Male ☐Female

CHROMOSOME ANALYSIS

√	Test Name	Test code
☐	Bone Marrow, Analysis	CG BONE MRW
☐	Peripheral Blood , Analysis WBC___, % BLASTS__	CG BLD NEO
☐	Tumor, Analysis (Diagnosis:_____)	CG TUM
☐	Peripheral Blood, Analysis or constitutional karyoytpe analysis only	CG BLOOD

FISH ANALYSIS

√	Test Name	Test code
☐	5q, FISH	CGFi 5Q
☐	7q, FISH	CGFi 7Q
☐	13q, FISH	CGFi 13Q
☐	20q, FISH	CGFi 20Q
☐	ABL1, FISH	CGFi ABL1
☐	ABL2, FISH	CGFi ABL2
☐	ALK, FISH	CGFi ALK
☐	BCL2 FISH	CGFi BCL2
☐	BCL6, FISH	CGFi BCL6
☐	BCR/ABL1, FISH	CGFi BCR
☐	CCND1/IGH	CGFi t(11;14)
☐	CHIC2, FISH	CGFi CHIC2
☐	Chrom. #1 Copy Number	CGFi 1Q1P
☐	Chromosome Enum. 1-3, FISH	CGFi ENUM
☐	CLL panel (+12, ATM, del(13q), P53)	CGFi CLL
☐	CRLF2, FISH	CGFi CRLF2
☐	CSF1R, FISH	CGFi CSF1R
☐	EPOR, FISH	CGFi EPOR
☐	ETV6, FISH	CGFi ETV6
☐	ETV6/RUNX1, FISH	CGFi TEL
☐	EWSR1, FISH	CGFi EWSR1

√	Test Name	Test code
☐	FGFR1, FISH	CGFi FGFR1
☐	FOXO1, FISH	CGFi FOXO1
☐	IGH, FISH	CGGi IGH
☐	IGH/BCL2, FISH	CGFi t(14;18)
☐	IGH/FGFR3, FISH	CGFi t(4;14)
☐	IGH/MAF, FISH	CGFi t(14;16)
☐	IGH/MAFB, FISH	CGFi t(14;20)
☐	inv(16), FISH	CGFi inv(16)
☐	MDS panel (del(5q), -7/del(7q), +8, del(20q))	CGFi MDSpan
☐	KMT2A (MLL), FISH	CGFi MLL
☐	MYC, FISH	CGFi MYC
☐	Myeloma panel (t(11;14), del(13q), P53, reflex t(4;14), t(14;16), 1e/1p, hyperdiploidy)	CGFi MMpan
☐	P53, FISH	CGFi P53
☐	PDGFRB, FISH	CGFi PDGFRB
☐	PML/RARA, FISH	CGFi APL
☐	RUNX1T1/RUNX1, FISH	CGFi t(8;21)
☐	SS18, FISH	CGFi SS18

☐ OTHER TESTS (Be Specific)_____

STANFORD SPECIMEN REQUIREMENTS

For Specimen collection questions you may call the testing laboratory at the phone number listed next to the department name or contact our Customer Service department at 1-877-717-3733.
Specimen requirements can also be found on www.stanfordlab.com.

First sample collected should always be a green top (sodium heparin) tube when Blood, Chromosome Analysis is requested.

CHROMOSOME ANALYSIS & FLUORESCENCE IN SITU HYBRIDIZATION (FISH)	**Lab Phone Number (650) 725-6396**
Chromosome Analysis and FISH testing can be performed from a single patient sample if volume is adequate	
Bone Marrow	· Minimum 1-2 mL · Green-top (sodium heparin) tube · Maintain specimen at room temperature
Whole Blood	· Minimum 4 mL · Green-top (sodium heparin) tube · Maintain specimen at room temperature
Tissue	· 0.5-1 cm^3 tissue · Sterile tube containing RPMI cell culture media, Sterile saline acceptable if media unavailable

Ship to:
If shipping Friday check for Saturday delivery
Phone: 1 (877) 717-3733

Stanford Anatomic Pathology and Clinical Laboratory
Attn: Specimen Processing
3375 Hillview Ave
Palo Alto, CA 94304

Shipper's Responsibility: The shipper is required to comply with the rules and guidelines for transport of medical specimens as set forth by the United States government, the government of the country of origin and international regulatory agencies. Failure to follow instructions for packaging and shipping specimens can result in the delay, loss or destruction of your specimens. Stanford University Medical Center Clinical Laboratories will not be held responsible for any liability attributable to the shipper's improper actions or failure to comply with regulations.

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Section 1862(a)(1)(A) of the Social Security Act states, "no payment may be made under Part A or Part B for any expense incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of any illness or to improve the functioning of a malformed body member." Tests submitted for Medicare reimbursement must meet program requirements or the claim may be denied. @ This test is subject to Medicare NCD or LCD, coverage is limited to certain diagnoses that support medical necessity.

Patient's First Name: _____

Patient's Last Name: _____

Patient's MRN: _____

Or Affix Label Here

Stanford HEALTH CARE

STANFORD MEDICINE

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.