

**Division of Pathology / Laboratory Medicine
 Outreach Services
 Test Requisition**

**SHIP MICROBIOLOGY, FLOW CYTOMETRY, HLA AND
 CYTOGENETICS TESTING TO:**

1515 Holcombe Blvd., R4.1446 (Unit 72)
 Houston, Texas 77030
 PHONE: (713) 794-1093 OR 1094
 FAX: (713) 745-1994
 CONTINENTAL US : 1-800-315-8424

SHIP MOLECULAR TESTING ONLY TO :

8515 FANNIN NA1.075 (Unit 149)
 Houston TX 77030

***Required Fields**
 PHYSICIAN / FACILITY / CLIENT INFORMATION

*REQUESTING PHYSICIAN		*UPIN / NPI NUMBER	
*PHONE	EXT	*FAX	HOSPITAL / OFFICE
ADDRESS	CITY	STATE	ZIP
PATIENT INFORMATION			
LAST NAME	FIRST NAME	DOB	SEX
ID NUMBER	PT. PHONE	SSN	
PT. ADDRESS	CITY	STATE	ZIP
INSURANCE PROVIDER	POLICY NUMBER	PHONE NUMBER	

SPECIMEN INFORMATION: Collection Date: ____/____/____ Time: ____ A / P

Specimen Type: Serum Plasma BM Urine PB Other _____

Diagnosis: _____

MICROBIOLOGY

- CMV Antigenemia
- Glactomanan (Aspergillus Ag)

FLOW CYTOMETRY

- Acute Leukemia Screen Panel
- B-CLL/B-Cell Lymphoma Panel
- Limited B-CLL Panel (CD5/CD19/CD38, kappa, lambda)
- Hairy Cell Leukemia Panel
- Myeloma Panel
- Waldenstrom's Panel
- T-Cell Lymphoma/Mycosis Fungoides (MF) Panel
- Immunodeficiency Panel
- CD4/CD8 ratio (PB only)
- Transplant Panel
- CD34 Assay
- Other Markers Please specify: _____

MOLECULAR DIAGNOSTICS

Leukemia/Lymphoma Testing

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> IGH/B-cell clonality (PCR) <input type="checkbox"/> TCR-beta/T-cell clonality (PCR) <input type="checkbox"/> TCR-gamma/T-cell clonality (PCR) <input type="checkbox"/> BCR-ABL - t(9;22) (quantitative PCR) <input type="checkbox"/> BCR-ABL mutation (full kinase domain sequencing) <input type="checkbox"/> BCR-ABL quantitative sequencing (codons 311-317/ including T315I) <input type="checkbox"/> NPM1 mutation (AML) <input type="checkbox"/> KRAS/NRAS mutation (AML/MDS) <input type="checkbox"/> KIT mutation (AML, exons 8/17) <input type="checkbox"/> Acute myeloid/lymphoid leukemia PCR screen: t(1;19), t(4;11), t(8;21), t(9;22), t(12;21), t(15;17), inv (16) | <ul style="list-style-type: none"> <input type="checkbox"/> KIT mutation in mast cell disease (real-time PCR) <input type="checkbox"/> FIP1L1 / PDGFRA <input type="checkbox"/> t(15;17) (quant PCR) <input type="checkbox"/> t(8;21) (quant PCR) <input type="checkbox"/> Inv 16 (quant PCR) <input type="checkbox"/> t(11;14) (quant PCR) <input type="checkbox"/> t(14;18) mbr (quant PCR) <input type="checkbox"/> t(14;18) mcr (quant PCR) <input type="checkbox"/> Somatic Hypermutation (CLL) <input type="checkbox"/> MPL mutation <input type="checkbox"/> JAK2 mutation (V617F) <input type="checkbox"/> JAK2 Exon 12 mutation <input type="checkbox"/> CLL panel by array CGH <input type="checkbox"/> CEBPA mutation |
|---|--|

HISTOCOMPATIBILITY – HLA

PATIENT TYPING

- HLA – Class I, Molecular [2L]
- HLA – Class II, Molecular [2L]
- Platelet Antibody
- Other _____

DONOR TYPING

- HLA Class I Molecular
- HLA Class II Molecular

DONOR INFORMATION

Last Name: _____ First Name: _____
 DOB: _____ Sex: _____ Race: _____
 SSN or passport #: _____
 Relationship to Patient : _____

Transplant Studies

- Post Transplant Quantitative Chimerism Analysis:
- T-cells (lineage-specific cell sorting)
- Myeloid cells (lineage-specific cell sorting)

Molecular for Solid Tumors (See Sample Requirements)

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Microsatellite Instability <input type="checkbox"/> BRAF mutation (exons 11 or 15/codon 600) <input type="checkbox"/> KIT mutation (GIST/Sarcoma) <input type="checkbox"/> 18qLOH (Colon Ca) <input type="checkbox"/> MLH1 Methylation <input type="checkbox"/> KRAS mutation | <ul style="list-style-type: none"> <input type="checkbox"/> PIK3CA mutation <input type="checkbox"/> EGFR mutation <input type="checkbox"/> NRAS mutation |
|---|--|

CYTOGENETICS

- Conventional chromosome analysis
- Fluorescence in situ hybridization (FISH)
Specify Probe: _____

DISCLOSURE

Disclosure of your social security number (SSN) is requested from you in order for The University of Texas M.D. Anderson Cancer Center to process your request for diagnostic services. No statute or other authority requires that you disclose your SSN for this purpose and we may not deny services if you choose not to disclose it. Failure to provide your SSN, however, may result in the creation of a duplicate patient number being issued, which may lead to multiple medical records. Further disclosure of your SSN is governed by the Texas Public Information Act and other applicable law.

For questions related to the above information call at (800) 315-8424 or Fax (713) 745-1994.

ADDITIONAL TESTS OR COMMENTS

[Http://www3.mdanderson.org/depts/pathology/hematopathology/index.htm](http://www3.mdanderson.org/depts/pathology/hematopathology/index.htm)

**U.T. M.D. ANDERSON CANCER CENTER
DIVISION OF PATHOLOGY AND LABORATORY MEDICINE
ADMISSIONS AND NEW PATIENT REGISTRATION**

Blood _____
Tissue _____
Slides _____

MR # _____

REGISTRATION REQUEST

1. PATIENT INFORMATION

PATIENT NAME: _____

PATIENT'S ADDRESS: _____

PATIENT'S PHONE: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT'S SOCIAL SECURITY #: _____

PATIENT'S SEX: _____ PATIENT'S MARITAL STATUS: _____

2. PRIMARY INSURANCE *will fax face sheet if secondary insurance is listed _____

INSURANCE COMPANY: _____

POLICY #: _____

ADDRESS: _____ TELEPHONE#: _____
_____ EFFECTIVE DATE: _____

GROUP PLAN NAME: _____ GROUP PLAN #: _____

INSURED'S NAME (if different from patient): _____

RELATIONSHIP TO PATIENT: _____

INSURED'S SS#: _____

INSURED'S DOB: _____

3. GUARANTOR INFORMATION

SELF: _____

OTHER: (NAME) _____
(ADDRESS) _____

(PHONE) _____

4. MDACC SERVICE CODE: _____

MDACC PHYSICIAN CODE: _____

5. CONSULT REQUESTED BY: _____

PH# : _____

Disclosure of your social security number (SSN) is requested from you in order for The University of Texas M.D. Anderson Cancer Center to process your request for diagnostic services. No statute or other authority requires that you disclose your SSN for this purpose and we may not deny services if you choose not to disclose it. Failure to provide your SSN, however, may result in the creation of a duplicate patient number being issued, which may lead to multiple medical records. Further disclosure of your SSN is governed by the Texas Public Information Act and other applicable law.

For questions related to the above information call at (800) 315-8424 or Fax (713) 745-1994.

(Instructions for Molecular Testing)

**UTMDACC
Molecular Diagnostics Laboratory
8515 Fannin Street, NA1.075
Houston, Texas 77054**

Collection and Transport of Specimens for Molecular Testing

To ensure optimum testing conditions for a specimen that is sent to the Molecular Diagnostic Laboratory (MDL) at MD Anderson Cancer Center (MDACC), the client should follow the below guidelines:

1. For ***Peripheral Blood**, collect 10-20 ml venous blood in EDTA (purple-top) vacutainer tubes.

For ***Bone Marrow**, collect 1-3 ml in EDTA. *It is important that a non-heparinized syringe is used for the initial bone marrow collection; then transferring the specimen to the sterile EDTA vacutainer tube **without using a needle to dispense the sample.***

For ***Solid Tumor testing**, send 5-6 slides containing 10um sections of paraffin-embedded tissue, along with a guide H&E-stained section. For 18q LOH/MSI studies, also have separate normal and tumor sections or indication of normal and tumor areas if on the same slide. A paraffin block can also be sent. Send at room temperature. Consult with lab for additional questions.

2. Identify the specimen(s) to be sent to MDL:
 - Patient's full name
 - Date of Birth (DOB)
 - Patient's MDACC# (if available)
 - Date and Time of Collection
 - Initials of Phlebotomist.
3. All EDTA tubes should be refrigerated immediately after collection and **shipped with cold pack** by overnight courier. **Extracted RNA or cDNA should be shipped frozen on dry ice.*
4. Samples should be shipped by overnight carrier to arrive Tuesday- Friday by 4:00PM. Call **713-794-4780** for additional information.

Sender is responsible for shipping charges.

***Shipping Address: UTMDACC
Molecular Diagnostics Laboratory
NA1.075
8515 Fannin Street
Houston, Texas 77054**

(Instructions for Cytogenetics Testing)

**UTMDACC
Cytogenetics Laboratory, Rm. R4.1443, Unit 350
1515 Holcombe Blvd,
Houston, Texas 77030**

**INSTRUCTIONS FOR COLLECTION AND SHIPMENT OF PATIENT
SPECIMEN FOR CYTOGENETICS TESTING**

For **Bone Marrow Collection**: Draw 1-2cc of bone marrow in sodium heparin.

For **Peripheral Blood Collection**: Draw 10-20 ml of venous peripheral blood, using sterile sodium heparin tube (green top).

Label tubes with the following:

- **Patient's full name**
- **Date of Birth**
- **Patient's UTMDACC Number (if registered through Outreach Department 1-800-315-8424)**
- **Date and Time of Collection**
- **Initials of Phlebotomist**
CBC Differential
- **Diagnosis if known**

Package tubes and requisition form in a suitable mailer, on a cold pack, and ship both back to UTMDACC, Cytogenetics Laboratory (at address above), using AIRBORNE Shipping (Customer/Sender must pay for shipping). Ship via AIRBORNE'S Overnight Delivery Service.

Please note that the laboratory is **open Monday through Friday 7:00am-11pm only**. We will not accept delivery on weekends, or holidays. Therefore, coordinate specimen collection and shipping within these days and times. Please contact us if you have any question regarding these instructions.

**Telephone 713-792-6330
FAX 713-745-3215**

Request for **Cytogenetics Testing only** should be sent to:

**UT MD ANDERSON CANCER CENTER
Cytogenetics Laboratory, Room R4.1443, Unit 350
1515 Holcombe Blvd.
Houston, Texas 77030**

(Instructions for Flow Cytometry Testing)

UTMDACC
Clinical Immunology, Rm. R4.2314, Unit 72
1515 Holcombe Blvd,
Houston, Texas 77030

INSTRUCTIONS FOR COLLECTION AND SHIPMENT OF PATIENT SPECIMEN FOR FLOW CYTOMETRY TESTING

For **Bone Marrow Collection**: Draw 1-2cc of bone marrow in 10 ml EDTA Tube.

For **Peripheral Blood Collection**: Draw 10 ml of venous peripheral blood, using 10 ml EDTA Tube.

Label tubes with the following:

- **Patient's full name**
- **Date of Birth**
- **Patient's UTMDACC Number (if registered through Outreach Department 1-800-315-8424)**
- **Date and Time of Collection**
- **Initials of Phlebotomist**
CBC Differential
- **Diagnosis if known**

Package tubes and requisition form in a suitable mailer, on a cold pack, and ship both to UTMDACC, Laboratory (at address above). Customer/Sender must pay for shipping. Ship via Overnight Delivery Service.

Please note that the laboratory is **open Monday through Friday 8:00am-10pm only**. We will not accept delivery on weekends, or holidays. Therefore, coordinate specimen collection and shipping within these days and times. Please contact us if you have any question regarding these instructions.

Telephone 713-792-3462
FAX 713-794-5541

Request for **Flow Cytometry Testing only** should be sent to:

UT MD ANDERSON CANCER CENTER
Clinical Immunology Lab, Rm. R4.2314, Unit 72
1515 Holcombe Blvd.
Houston, Texas 77030

(Instructions for HLA Testing)

**UTMDACC
Histocompatibility Laboratory
8515 Fannin, NAO1.075
Houston, Texas 77054**

**INSTRUCTIONS FOR COLLECTION AND SHIPMENT OF PATIENT
SPECIMEN FOR HLA TESTING**

For **Peripheral Blood Collection**: Draw venous peripheral blood, using sterile (2) 10 ml EDTA tubes and (1) 10 ml ACD tube.

Label tubes with the following:

- **Patient's full name**
- **Date of Birth**
- **Patient's UTMDACC Number (if registered through Outreach Department 1-800-315- 8424)**
- **Date and Time of Collection**
- **Initials of Phlebotomist**

Package tubes and requisition form in a suitable mailer, at room temperature, and ship both back to UTMDACC, HLA Laboratory (at address above), using UPS Shipping (Customer/Sender must pay for shipping). Ship via UPS' Overnight Delivery Service. Please note that the laboratory is **open Monday through Friday 7:30 am - 9:30 pm only**. We will not accept delivery on weekends, or holidays. Therefore, coordinate specimen collection and shipping within these days and times.

Please contact us if you have any question regarding these instructions.

**Telephone 713-792-2658
FAX 713-794-4773**

Request for **HLA Testing Only** should be sent to:

**UT M. D. ANDERSON CANCER CENTER
Histocompatibility Laboratory
8515 Fannin, NAO1.075
Houston, Texas 77054**

(Instructions for Microbiology)

**M.D. Anderson Cancer Center
Microbiology R4.1720 Unit 84
1515 Holcombe Blvd.
Houston TX 77030**

Collection and Transport of Specimens for Microbiology Testing

To ensure optimum testing conditions for a specimen, that is sent to the Microbiology Laboratory at MD Anderson, the client should follow the below guidelines:

1. For **CMV Antigenemia** collect a 10cc ACD-A (large yellow) tube.
For **Galactomanin (Aspergillus Ag)** collect a 7cc Red Top tube.
2. Identify the specimen(s) to be sent to Microbiology:
 - a. Patient's full name
 - b. Date of Birth
 - c. Patient's MDA medical record number (if available)
 - d. Date and time of collection
 - e. Initials of Phlebotomist
3. Specimens should be shipped on a cold pack.
4. Samples should be shipped by overnight carrier to arrive Tuesday – Friday by 8:00AM. **DO NOT** Ship specimen on Friday or Saturday. Call (713)792-3515 for additional information.
5. **Sender is responsible for shipping charges.**

Shipping address: **UTMDACC
Microbiology Lab, Rm. R4.1720, Unit 84
1515 Holcombe Blvd.
Houston, TX 77030**