University of Miami Medical Laboratories

CYTOGENETICS & MOLECULAR DIAGNOSTICS LABORATORY

CMDL REQUEST FORM 1

Accession No. _____
Received by _____
Date_____Time _____ am/pm
Amount of Sample _____
Condition of Sample _____

ATTENTION HEALTH CARE PROVIDERS **Medical Necessity**: Federal regulators require that only tests that are necessary for diagnosis and treatment of a patient's condition be ordered. ICD-9 Code is **required** to prove medical necessity of outpatients. Dr.'s name, phone number and ICD-9 Code are **absolutely required.**

PATIENT INFO: PLEASE PRINT ALL OF THE FOLLOWING INFORMATION

Last Name:_____ First Name:_____
Address:_____
City:_____ State:_____ Zip:_____
SS#: _____ - _____ - _____
Date of Birth: _____ /_____ /_____ Sex: M ❒ F ❒

ATTENDING PHYSICIAN INFORMATION (PLEASE PRINT LEGIBLY)

Test Order Date: _____ /_____ /_____Time Ordered:_____ am / pm
Ordering M.D. **Name:** _____
Ordering M.D. **Signature:** _____
Ordering M.D. **NPI #:** _____ **Beeper/Ph:** _____
Fax:_____ Hosp./Lab Name: _____
Address:_____
City:_____ State:_____ Zip:_____

Client. No. Telephone

Medical Record # _____

SPECIMEN INFORMATION

Collection Date: _____/_____/_____ Time:_____ am / pm
Collected By: _____Specimen Source:_____
❒ Bone Marrow ❒ Blood

CLINICAL INFORMATION

❒ **DIAGNOSIS or** ❒ **FOLLOW UP**

❒ CML ❒ AML ❒ AML-M3 ❒ ALL ❒ CLL
❒ Myelodysplastic Syndrome ❒ Multiple Myeloma
❒ Lymphoma (specify)_____ ❒ Other _____

PATIENT INSURANCE INFORMATION (IF APPLICABLE)

INSURED: _____ ❒ HMO ❒ PPO ❒ POS Insurance Co.: _____
Authorization # (if required): _____ Policy # _____ Medicare / Medicaid #: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: ( ) _____ Cell: ( ) _____ Fax: ( ) _____
Relationship to Insured: _____ Bill Credit Card#: _____ exp. _____

TESTS FOR HEMATOLOGICAL MALIGNANCIES

1601 NW 12th Avenue, MCCD 7050, Miami, Florida 33136 / Ph. (305) 243-6870 • Fax (305) 243-3805 • Toll Free: 800-VIA-CYTO

✔	TEST CODE	CLINICAL INDICATION	TEST DESCRIPTION	PROBE/CHROMOSOME REGION/GENE	CPT	ICD9
	1008	Cancer Study	Chromosome Analysis (Peripheral blood / Bone Marrow)	Chromosomes 1~22,X/Y	88237, 88261, 88280, 88291	
	1108	Cancer Study	Chromosome Analysis (Peripheral blood / Bone Marrow-Cell Pellet)	Chromosomes 1~22,X/Y	88261, 88280, 88291	
	1009	Cell culture only	Cell culture (bone marrow / peripheral blood)		88237	
	4002	AML	FISH	RUNX1/RUNX1T1 - t(8;21)	88368x2	
	4003	AML	FISH	PML/RARA - t(15;17)	88368x2	
	4016	AML	FISH	RARA (17q21.1)	88368x2	
	4005	AML	FISH	CBFB(16q22)	88368x2	
	4004	AML	FISH	MLL (11q23)	88368x2	
	4019	AML	FISH	DEK/NUP214 - t(6;9)	88368x2	
	4007	ALL	FISH	ETV6/RUNX1 - t(12;21)	88368x2	
	4001	ALL	FISH	BCR/ABL1 - t(9;22)	88368x2	
	5001	ALL	FISH	IGH (14q32)	88368x2	
	4004	ALL	FISH	MLL (11q23)	88368x2	
	4001	CML	FISH	BCR/ABL1 - t(9;22)	88368x2	
	4016	CML	FISH	RARA (17q21.1)	88368x2	
	4006	CML	FISH	CEP 8 (trisomy 8)	88368x1	
	4009	CLL	FISH	CEP 12, DS13S19, 13q34, ATM, TP53	88368x5	
	4013	Eosinophilia	FISH	FIP1L1/PDGFRA - (4q12)	88368x3	
	4008	Eosinophilia	FISH	PDGFRB (5q33)	88368x2	
	5008	Eosinophilia	FISH	FGFR1 (8p12)	88368x2	
	5008	MDS/MPN	FISH	EGR1 (5q31), D5S23, D5S721	88368x2	
	5008	MDS/MPN	FISH	CSF1R (5q33-q34), D5S23,D5S721	88368x2	
	5008	MDS/MPN	FISH	D7S486 (7q31), CEP 7	88368x2	
	5008	MDS/MPN	FISH	D20S108 (20q12), CEP 20	88368x2	
	5008	MDS/MPN	FISH	CEP 8 (trisomy 8)	88368x1	
	5008	MDS/MPN	FISH	BCR/ABL1 - t(9;22)	88368x2	
	5008	Myeloproliferative Disorders	PCR	JAK 2 mutation	81270, G0452	
	5008	Multiple Myeloma(MM)	FISH	D7S486 (7q31), CEP 7	88368x2	
	5008	Multiple Myeloma(MM)	FISH	IGH (14q32)	88368x2	
	5008	Multiple Myeloma(MM)	FISH	CCND1/IGH - t(11;14)	88368x2	
	5008	Multiple Myeloma(MM)	FISH	FGFR3/IGH - t(4;14)	88368x2	
	5008	Multiple Myeloma(MM)	FISH	IGH/MAF - t(14;16)	88368x2	
	5008	Multiple Myeloma(MM)	FISH	TP53 (17p13), CEP 17	88368x2	
	5008	Multiple Myeloma(MM)	FISH	D13S319 (13q14), 13q34	88368x3	
	5008	Multiple Myeloma(MM)	FISH	CEP 3,CEP 9,CEP 15		
		POST BONE MARROW TRANSPLANTATION				
		Same Sex	FISH	Refer to specific translocation/test #		
	6001	Opposite Sex	FISH	DXZ1 (CEP X), DYZ3 (CEP Y)	88368x2	
	5001 *5701	Lymphoma	FISH	IGH (14q32)	88368x2 88368x2	
	7001 *7701	Anaplastic Large- Cell Lymphoma	FISH	ALK (2p23)	88368x2 88368x2	
	7002 *7702	Burkitt Lymphoma	FISH	MYC/IGH/CEP8 - t(8;14)	88368x3 88368x3	
	7005 *7705	Burkitt Lymphoma	FISH	MYC (8q24)	88368x2 88368x2	
	7003 *7703	Follicular Lymphoma	FISH	IGH/BCL2 - t(14;18)	88368x2 88368x2	
	7007 *7707	MALT Lymphoma	FISH	IGH/MALT1 - t(14;18)	88368x2 88368x2	
	7010 *7710	MALT Lymphoma	FISH	BIRC3/MALT1 - t(11;18)	88368x2 88368x2	
	7008 *7708	MALT Lymphoma	FISH	MALT1 (18q21)	88368x2 88368x2	
	5002 *5702	Mantle Cell Lymphoma	FISH	CCND1/IGH - t(11;14)	88368x2 88368x2	
	7006 *7706	Diffuse Large B-cell Lymphoma	FISH	BCL6 (3q27)	88368x2 88368x2	
	7003 *7703	Diffuse Large B-cell Lymphoma	FISH	IGH/BCL2 - t(14;18)	88368x2 88368x2	
	7005 *7705	Diffuse Large B-cell Lymphoma	FISH	MYC (8q24)	88368x2 88368x2	
	7009	T-Cell Lymphoma	FISH	TRA/D (14q11)	88368x2	
			Other			

REFER TO LABORATORY COMPENDIUM FOR SPECIMEN INFORMATION. LAB TESTING WILL NOT BE PERFORMED IF LACKING COMPLETE INFORMATION.

ATTENDING PHYSICIAN ASSUMES RESPONSIBILITY FOR OBTAINING APPROPRIATE INFORMED CONSENT FOR GENETIC TESTING/COUNSELING.

FL AHCA: 800000842	Provider: L9260	
CLIA: 10D0279395	External Billing Area: PPSEC 1307	
Medicare: L9260	Internal Billing Area: PPSIC 1308	
Medicaid: 05-7829100	Tax ID No.: 59-2695890	Facility: PSS

I hereby authorize this request for professional services to be rendered and billed by the above captioned laboratory. I further authorize the release of any medical information required by insurance carrier or MEDICAID / MEDICARE carrier.

Distribution: White—Billing Yellow—Lab Pink—Client / Rev. 08/11

Signature :

(* Test number for FISH on paraffin slides)