Spectrum Health Regional Laboratories - Advanced Technology Requisition (Patient Bill)

REQUIRED PROVIDER/OFFICE INFORMATION:

ID:_____ Name:_____

Address:_____

Phone:_____ Fax:_____

Provider Name: _____
PRINT First and Last Name. No Initials.

NPI *(optional)*:_____

Provider Signature: _____

Date ordered	Date collected	Time collected	Collector

Patient Information - REQUIRED

Name Last First MI

Address Phone

City State Zip

Sex Marital Status Birth date Cell Phone

Billing - REQUIRED

Attach a copy of face sheet and insurance card. Specimen will be registered as patient self-pay and bill be the responsibility of the patient if information is not provided.

Bill to:

Patient or Insurance Name_____

Policy Number_____

Note: Medicare will only pay for tests that meet the Medicare definition of "Medical Necessity". Medicare may deny payment for a test that the physician believes is appropriate, such as a screening test. Be certain the patient has signed the Advanced Beneficiary Notice (ABN) CMS-R 131 as needed.

Additional Reports to

Name Fax

Name Fax

Diagnosis Code(s) - REQUIRED

1.
2.
3.

SAMPLE TYPE

❍ Blood ❍ Bone Marrow ❍ Lymph Node ❍ Skin Biopsy
❍ Solid Tumor, type _____ ❍ Fluid, type_____ ❍ Amniotic Fluid** ❍ Chorionic Villi**
❍ Tissue Surgical #_____ Type_____ **EDD ____/____/_____ by ❍ LMP ❍ U/S **Gest Age ____wks
❍ Products of Conception* ❍ Fetal Autopsy* **Biochemical Markers** (Amniotic Fluid Only)
Tissue Type(s)_____ *Gest Age ____wks ❍ Alpha-Fetoprotein ❍ Acetylcholinesterase

CYTOGENETICS

Fluorescence In-Situ Hybridization (FISH)*
*Diagnostic bone marrow specimens include chromosome study

Hematologic/Neoplastic Disorders
❍Monitor Previously Identified Abnormalities
❍ALK (2p23) Rearrangement
❍Acute Myeloid Leukemia (AML) Probe Panel
❍B-Acute Lymphocytic Leukemia (B-ALL) Probe Panel
❍BCR and ABL1 T(9;22)
❍Burkitt's Probe Panel
❍CHIC2, 4q12 Deletion (FIP1L1, PDGFRA Rearrangement)
❍CHOP (DDIT3) Rearrangement
❍Chronic Lymphocytic Lymphoma (CLL) Probe Panel
❍Diffuse Large B-Cell Lymphoma (DLBCL) Panel
❍Eosinophilia (EOS) Probe Panel
❍EWSR1 Rearrangement (22q12)
❍FKHR (13q14) Rearrangement
❍Follicular Lymphoma Probe Panel
❍FUS (16p11) Rearrangement
❍Glioma (1p36/19q13)
❍Her-2/neu (ERBB2) Amplification
❍Mantle Cell Lymphoma IGH and CCND1 t(11;14)
❍MDM2 Amplification
❍MET Amplification
❍MLL (11q23) Rearrangement
❍Multiple Myeloma Probe Panel
❍MYC Rearrangement
❍Myelodysplastic Syndrome (MDS) Probe Panel
❍N-MYC (2p24) Amplification
❍PML and RARA t(15;17)
❍RET Rearrangement
❍ROS1 Rearrangement
❍T-Acute Lymphocytic Leukemia (T-ALL) Probe Panel
❍Bone Marrow Transplant Status (Opposite Sex) (XX/XY)
❍Other: _____

Constitutional Deletions/Duplications
❍DiGeorge/VCFS (22q11.2)
❍Gender XX and XY (includes SRY)
❍POC Aneuploid Screen (XY, 13, 16, 18, 21)
❍Prader Willi/Angelman (15q11-q13)
❍Prenatal Aneuploid Screen (XY,13,18,21)
❍Smith Magenis 17p11
❍Trisomy 21
❍Turner Syndrome
❍Williams (7q11.23)
❍Other: _____

Chromosomal Microarray (aCGH)
❍Microarray, Chromosomal (aCGH)
❍Confirmatory FISH for Microarray

Chromosome Analysis (Sodium Heparin)
❍Chromosome Analysis Hematologic or Neoplastic Study*
*For bone marrow, provide WBC and Diff
Lymphoma or other B-cell process suspected? ❍Yes ❍No

CYTOGENETICS

Constitutional Study
❍Chromosome Analysis Constitutional (Routine)
❍Chromosome Analysis Prenatal
❍Chromosome Analysis Constitutional Mosaic
❍Chromosome Analysis High Resolution (Blood Only)
❍Chromosome Analysis Products of Conception (POC)*
*Tissue Pathology Required

Other
❍Cytogenetics Fibroblast Culture with Cryopreservation*
❍Cytogenetics Fibroblast Culture for Reference Testing with Cryopreservation (Send out)*

FLOW CYTOMETRY

Immunophenotyping
❍Leukemia/Lymphoma/Myeloma Panel
❍B-ALL MRD Blood
(COG B-ALL Day 8 Protocol AALL0932 or AALL1131)
❍B-ALL MRD, Blood
Indicate Timepoint in Therapy: _____
❍B-ALL MRD, Bone Marrow
(COG B-ALL Day 29 Protocol AALL0932 or AALL1131)
❍B-ALL MRD, Bone Marrow
Indicate Timepoint in Therapy: _____
❍HLA B27 Screen
❍Fetal Cells by Flow Cytometry
❍CD20 and CD19
❍Paroxysmal Nocturnal Hemoglobinuria (PNH)
❍Leukocyte Adhesion Deficiency (LAD)

Immune Competency Testing
❍Lymphocyte Subsets (CD3, CD4, CD8, CD16, CD56, CD19)
❍T-Cell Subsets (CD4, CD8, CD3, CD19)
❍CD4 Percent and Cell Count
❍SCID Screen (Severe Combined Immunodeficiency)
❍ALPS Screen (Autoimmune Lymphoproliferative Syndrome)

Functional Tests
❍Oxidative Burst

Other – Call 616-486-6273 to Schedule
❍Cell Sort (for CD3)
❍Cell Sort (for CD15)
❍Other: _____

MOLECULAR DIAGNOSTICS

Bone Marrow Engraftment Testing
❍Pre Bone Marrow Engraftment, Donor
❍Pre Bone Marrow Engraftment, Recipient
❍Post Bone Marrow Engraftment
❍Killer Cell Immunoglobulin-Like Receptors (KIR)

MOLECULAR DIAGNOSTICS

Infectious Disease
❍APTIMA Chlamydia Gonococcus NAAT
❍APTIMA Chlamydia NAAT
❍APTIMA Gonococcus NAAT
❍APTIMA Trichomonas NAAT
❍HPV High Risk Screen
❍HPV 16/16 Genotype

❍Adenovirus Quantitative PCR
❍CMV Quantitative PCR
❍EBV DNA Quantitative
❍Hepatitis B Virus DNA Quantitative by PCR
❍Hepatitis C Virus RNA Quantitative by RT-PCR
❍Hepatitis C Genotype w/Amplification
❍Hepatitis C Genotype 1a NS5A Drug Resistant
❍HIV 1 RNA Quantitative PCR
❍Herpes Simplex PCR (CSF and Plasma)

Inherited Disease
❍Cystic Fibrosis Carrier Screen
❍Hemochromatosis DNA (HFE C282Y & H63D)
❍Prader Willi/Angelman mPCR
❍Factor V Leiden DNA Analysis
❍MTHFR C677T
❍Prothrombin G20210A Mutation (Factor II)

Oncology Testing
❍Epi proColon, Septin 9 Methylation
❍Colon Mutation Analysis Panel
❍Lung Cancer Mutation Analysis
❍BRAF Mutation Analysis by Next Generation Sequencing
❍EGFR Mutation Analysis
❍KRAS Mutation Analysis
❍NRAS Mutation Analysis
❍Microsatellite Instability (MSI) PCR
❍MLH1 Promoter Hypermethylation
❍MGMT Methylation Analysis
❍Cancer Hotspot Analysis by Next Generation Sequencing
❍ODC1 Genotype Ana
❍BCR-ABL1 t[9;22] RT- PCR
❍JAK2 V617F Mutation Analysis, MPN if Negative
❍MPN Expanded Panel
❍IDH1 and IDH2 Mutation Analysis
❍CEBPA Mutation Analysis
❍KIT Mutation Analysis
❍NPM1 Mutation Analysis
❍MYD88 Mutation Analysis
❍Heme Molecular Sequence Analysis
❍Immunoglobulin Heavy (IgH) Chain PCR for B-Cell Clonality
❍T-cell Gamma Receptor (TCR) PCR for T-Cell Clonality
❍DNA Extraction and Hold

Provider responsible for documenting informed consent prior to ordering genetic testing.

Label specimen with 2 patient identifiers (name and date of birth) **Specimen Collection Catalog - http://spectrumhealth.testcatalog.org** **Call Center Phone: 616-774-7721**

White – Lab **Yellow – Lab** **Pink – Ordering Provider**

Template: SH LAB ATL PATIENT BILL (6/2020) **For a list of Draw Sites visit spectrumhealth.org/locations**