THE UNIVERSITY OF CHICAGO MEDICINE

UChicago MedLabs
5812 S. Ellis Avenue
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Chicago, IL 60637
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UChicago MedLabs

1. PATIENT INFORMATION – Required

Name _____

DOB _____ Sex _____ SS# _____

Street _____

City _____ State _____ Zip _____

Phone _____

2. CLIENT INFORMATION - Required

Institution/Group Practice: _____

Address: _____

City:_____ State:_____ Zip: _____

Phone: _____ Fax:_____

_____ _____
Ordering Physician NPI

3. BILLING CLASSIFICATION: Check only one box. If no box is checked, UChicago MedLabs will bill Client.
Please see Requisition Form Instructions for additional information.

☐ **BILL CLIENT**

Client Account Code: _____

☐ **BILL PATIENT INSURANCE** Complete Section 4
Please check for HMO authorization.

☐ Check here if prior authorization/ referral form is attached. Failure to include may result in coverage denial.

☐ Check here if patient is self-pay and is aware that they will billed for our services. Bills will be sent to the address listed in box 1.

Patient Signature_____

4. PATIENT INSURANCE INFORMATION * * Please attach a copy of the front/back of patient's insurance card(s) * *

_____ _____ _____ _____
Subscriber (if different from patient) DOB Relationship SS#

Primary Insurance Co. _____

_____ _____
Policy Number Group Number

_____
Insurance Company Address

Secondary Insurance Co. _____

_____ _____
Policy Number Group Number

_____
Insurance Company Address

5. SPECIMEN INFORMATION – Required

Specimen Type: ☐ **Blood** ☐ **DNA** ☐ **Amino / CVS** ☐ **Other**

Collection Date: _____

ICD10#:_____ _____ _____

Clinical or Family History: _____

Diagnosis: _____

6. REQUESTED TESTS

	NEXT-GENERATION SEQUENCING
☐	**OncoScreen 2.0** next-generation sequencing panel of 50 genes associated with increased risk for cancer *(ABL1, AKT1, ALK, APC, ATM, BRAF, CDH1, CDKNS1, CSF1R, CTNNB1, EGFR, ERB2, ERBB4, EZH2, FBXW7, FGFR1, FGFR2, FGFR3, FLT3, GNA11, GNAQ, GNAS, HNF1A, HRAS, IDH1, IDH2, JAK2, JAK3, KDR, KIT, KRAS, MET, MLH1, MPL, NOTCH1, NPM1, NRAS, PDGFRA, IK3CA, PTEN, PTPN11, RB1, RET, SMAD4, SMARCB1, SMO, SRC, STK11, TP53, VHL)*
☐	**OncoHeme** next-generation sequencing panel of 53 genes associated with increased risk for hematologic malignancies *(ABL1, ASXL1, ATRX, BCOR, BCORL1, BRAF, CALR, CBL, CBLB, CBLC, CDKN2A, CSF3R, CUX1, DNMT3A, ETV6, EZH2, FBXW7, FLT3, GATA1, GATA2, GNAS, HRAS, IDH1, IDH2, IKZF1, JAK2, JAK3, KDM6A, KIT, KRAS, MLL, MPL, MYD88, NOTCH1, NPM1, PHF6, PTEN, PTPN11, RAD21, RUNX1, SETBP1, SF3B1, SMCA1, SMC3, SRSF2, STAG2, TET2, TP53, U2AF1, WT1, ZRSR2)*
☐	**RAS Targeted Gene Panel** next-generation sequencing panel useful for identifying mutations that may help determine prognosis for patients with solid tumors by evaluating somatic mutations within the *HRAS (exons 2 and 3), NRAS (exons 2,3,4),and KRAS (exons 2,3,4)* genes

	MOLECULAR DIAGNOSTICS		SOLID TUMOR FISH TESTING		CYTOGENETIC TESTING
☐	BCR-ABL (P210 and P190) Assay, Quant (Blood)	☐	HER2 FISH, breast	☐	Routine chromosome analysis*
☐	BCR-ABL Mutation Assay (Blood)	☐	HER2 FISH, gastric	☐	Routine chromosome analysis mosaic work up
☐	cKIT Mutation Assay (Blood)	☐	ALK FISH	☐	Reflex** to SNP array if chromosome results are normal
☐	FLT-3 Mutation Detection (Blood)	☐	1p/19q FISH	☐	SNP Array – Constitutional studies
☐	JAK2 V617FMutation (Exon14) Assay (Blood)	☐	UroVysion (bladder wash or urine)	☐	Reflex** chromosome analysis if SNP Microarray is normal
☐	NPM Mutation Assay (Blood)	☐	Custom FISH (please call the laboratory)	☐	Cell culture, storage & freezing of cells

*For routine chromosome analysis: reflex STAT (3-4 day) prelim results available at request for infants <1 month of age. Reflex to mosaic study will be performed when sex chromosome aneuploidy is suspected based on the indication provided.

**Additionalcharge for reflextesting

Print Form