

BCR-ABL TEST REQUISITION

PHYSICIAN / FACILITY / CLIENT INFORMATION _____ PHYSICIAN _____ UPIN _____ PHONE _____ EXT _____ FAX _____ DEPARTMENT _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ CONTACT PERSON _____ AUTHORIZED SIGNATURE _____	PATIENT INFORMATION _____ LAST NAME _____ FIRST NAME _____ DOB _____ SEX _____ PATIENT ID NUMBER _____ PATIENT PHONE _____ SSN _____ PATIENT ADDRESS _____ CITY _____ STATE _____ ZIP _____
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BILLING		
BILL TO: <input type="checkbox"/> Pharma Contract <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Patient <input type="checkbox"/> Other: _____		
POLICY HOLDER: <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian		
INSURANCE COMPANY _____		NAME OF INSURED _____
INSURANCE BILLING ADDRESS _____		
POLICY NUMBER _____	GROUP NUMBER _____	PHONE NUMBER _____
ICD-9 CODE(S) _____	CYTOLOGICAL DIAGNOSIS _____	AUTHORIZATION/REFERRAL NUMBER _____
<input type="checkbox"/> SELF PAY <input type="checkbox"/> PAYMENT ENCLOSED AMOUNT _____		
CREDIT CARD <input type="checkbox"/> MC <input type="checkbox"/> VISA <input type="checkbox"/> AMEX <input type="checkbox"/> DISCOVER CARD # _____ EXP. DATE _____		
CARD HOLDER NAME _____		SIGNATURE _____
<small>Note: Provide a copy of insurance card, authorization and authorized signature</small>		

SPECIMEN INFORMATION		Collection Date: ____/____/____	Collection Time: ____ AM/PM
Specimen Type: <input type="checkbox"/> Peripheral Blood <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Other: _____			
Specimen Tube:	EDTA: Number _____ Volume: <input type="checkbox"/> 2.5ml <input type="checkbox"/> 5ml <input type="checkbox"/> 7.5ml <input type="checkbox"/> 10ml		
	PAXgene: Number _____ Volume: <input type="checkbox"/> 2.5ml <input type="checkbox"/> 5ml <input type="checkbox"/> 7.5ml <input type="checkbox"/> 10ml		
Specimen collected by _____		Specimen ID number _____	
Phase:	<input type="checkbox"/> Chronic <input type="checkbox"/> Acute <input type="checkbox"/> Blastic	Diagnosis: <input type="checkbox"/> New Diagnosis <input type="checkbox"/> Relapse <input type="checkbox"/> Monitoring <input type="checkbox"/> MRD	
Treatment:	<input type="checkbox"/> Untreated <input type="checkbox"/> Gleevec® <input type="checkbox"/> Sprycel® <input type="checkbox"/> BMT <input type="checkbox"/> Other: _____		

TESTS		
LEUKEMIA/LYMPHOMA TRANSLOCATIONS		
<input type="checkbox"/> BCR-ABL RNA Quantitation (Major Breakpoint BCR b2a2,b3a2)		
<input type="checkbox"/> BCR-ABL T315I Mutation (FRET)	<input type="checkbox"/> BCR-ABL Kinase Domain Mutation (Sequencing)	

RESULTS
A hard copy of the results will be mailed to the requesting physician's office. If you would also like a copy faxed or emailed, please indicate below.
<input type="checkbox"/> Fax _____ <input type="checkbox"/> Email _____

REQUESTS, PATIENT HISTORY, OR COMMENTS

Requisition form completed by _____
