CANCER CYTOGENETICS REQUEST FORM Cytogenetics Laboratory UNC Hospitals; McLendon Laboratories and Department of Pediatrics Room 1071, 1st Floor Memorial Hospital 101 Manning Drive Chapel Hill, NC 27514 Phone: (984) 974-1790 Fax: (984) 974-1666	Medical Record #: Patient Name: Date of Birth: Sex: **Specimen Type:**_____________ Date: (required) Time: Bone Marrow # ________________________________ WBC X 10^3 % Blasts_________
Attending physician requesting study: Office address: Phone Number: Pager # :	**For lab use only** **Lab No:** **Date Rec'd:**

CLINICAL DATA:

1. Priority Status (**note**: a 10 cell preliminary analysis will be done on all cases within 3 working days of sample receipt, regardless of priority status)

RUSH ☐ **ASAP** ☐ **ROUTINE** ☐

2. Please check test(s) being requested:

ROUTINE CYTOGENETICS ONLY ☐ **FISH ONLY** ☐ **ROUTINE CYTOGENETICS AND FISH** ☐

Indicate specific FISH probe in box below

☐ (BCR/ABL); t(9;22)	☐ (TEL/AML1); t(12;21)	☐ (PML/RARA); t(15;17)	☐ MLL (11q23)
☐ N-Myc (2p24)	☐ X/Y (unlike sex BMT)	☐ AML1/ETO: t(8;21)	☐ inv(16)
☐ IGH/BCL2: t(14;18)	☐ MYC/IGH: t(8;14)	☐ CCND1/IGH: t(11;14)	
☐ Multiple Myeloma panel	☐ CLL panel	☐ Other ________________________	

3. Is this patient infectious? ☐ No ☐ Yes; If yes, what organism? ____________________________

4. Type of hematologic disorder (please check):

☐ ALL ☐ CML ☐ MM
☐ AML (FAB subtype - ______) ☐ MDS ☐ Lymphoma (Type____________)
☐ CLL ☐ MPD ☐ Other______________________

5. If you suspect a specific chromosome abnormality, please indicate which one ____________________

6. Patient Status (check all that apply):

☐ Diagnostic ☐ Remission ☐ Relapse/blast crisis ☐ Other
☐ Pretreatment ☐ Post BMT (date and type of transplant__________________)
☐ Pre BMT ☐ Recent treatment___________________________________

7. Is this a protocol patient? ☐ No ☐ Yes (☐ COG ☐ CALGB ☐ Other ____________)

8. If this patient has been previously karyotyped at another institution (not UNC), please **indicate institution and results**:____

Please note: Submission of a sample to the Cytogenetics Laboratory accompanied by this form will be considered authorization to perform routine cytogenetic testing including tissue culture, counting additional cells, special staining, and fluorescence in situ hybridization (FISH) as deemed appropriate by the laboratory directors. **SEE BACK FOR ADDITIONAL INFORMATION.**

Physician Signature: ___________________________________ **Date:**_________________