OncoMetrix™
Definitive Cancer Diagnostics

Please Call Customer Service for Pick-up
Customer Service: 877.670.HEME (4363)
3495 Hacks Cross Rd, Memphis, TN 38125
www.oncometrix.com

Req # here

HEMATOLOGY/ONCOLOGY REQUISITION

CLIENT INFORMATION

Referring Physician and NPI # | Referring Physician Fax #

PATIENT INFORMATION

Last Name | First Name | MI

DOB | Social Security # | Patient Phone

Gender | Collection Date and Time / / ❑ AM ❑ PM

Street Address | Apt #

City | State | ZIP

Medical Record # | Next Appointment Date

BILLING INFORMATION

*Face Sheet and front and back of both the PRIMARY and SECONDARY insurance cards **MUST BE INCLUDED**. Please do not attach credit card info to this form.*

ICD-10 Code(s) (Please provide as many symptomatic diagnosis codes as applicable): _____ _____ _____ _____ _____ _____

Patient Status: ❑ Hospital Inpatient (>24 hour stay) Discharge Date: _____ ❑ Hospital Outpatient ❑ Non-Hospital Patient

Bill: ❑ My Account/Client Bill ❑ Insurance ❑ Medicare ❑ Medicaid ❑ Patient

Primary: _____
Policy # _____ Group # _____
Insured Name _____ DOB_____
Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

Secondary: _____
Policy # _____ Group # _____
Insured Name _____ DOB_____
Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

INDICATIONS FOR TESTING/ANALYSIS

Attach a copy of patients clinical history, including current CBC.

Clinical Narrative: _____

SPECIMEN INFORMATION

Specimen ID #(s) _____ Has OncoMetrix previously performed testing on this patient? ❑ Yes ❑ No

Clinical Status: ❑ New Diagnosis ❑ Staging ❑ Monitoring ❑ MRD ❑ Post/Under Therapy

Bone Marrow Biopsy: ❑ Fixed Core ❑ Fixed Clot ❑ Core/Paraffin Block ❑ Clot/Paraffin Block ❑ Fresh Core ❑ Touch Prep(s)

Bone Marrow Aspirate: ❑ Sodium Heparin Green Top(s) ❑ EDTA Lavender Top(s) ❑ Smears

Peripheral Blood: ❑ Sodium Heparin Green Top(s) ❑ EDTA Lavender Top(s) ❑ Smears

Tissue Biopsy: Tissue Type _____ Tissue Location _____ ❑ Fresh/Not Fixed ❑ B Plus Fixed ❑ RPMI ❑ Paraffin Block(s)

Other (FNA, Body Fluid, etc. - Include Location): _____

MENU OF TESTS AND SERVICES (CHOICE REQUIRED) All tests included in SCOPE may also be ordered individually below.

SCOPE
Diagnostic Consultative Evaluation

SCOPE Includes: Clinical history review, morphologic assessment, and flow cytometry. May include cytogenetics, FISH, molecular, and/or next-generation sequencing testing as medically necessary. A summary with correlation of all testing technologies will be incorporated into one final comprehensive diagnostic SCOPE Report. *(Please attach current CBC for all SCOPE tests)*

❑ **SCOPE for Bone Marrow Evaluation** ❑ **SCOPE for Blood Evaluation**

Morphology/Morphologic Consult

❑ Bone Marrow Core ❑ Bone Marrow Clot
❑ Bone Marrow Smears ❑ Blood Smears
❑ Other _____

FISH Panels (Fluorescent In Situ Hybridization)

See panel descriptions on back of requisition

❑ ALL (Pediatric) ❑ Multiple Myeloma
❑ ALL (Adult) ❑ Eosinophilia
❑ AML ❑ B-Cell Lymphoma
❑ CLL ❑ T-Cell Lymphoma
❑ CML ❑ MDS
❑ Individual FISH Probe(s): _____
(Choose from comprehensive FISH test menu on back of requisition)

Flow Cytometry

❑ Leukemia/ Lymphoma Panel
❑ Paroxysmal Nocturnal Hemoglobinuria (PNH)

Cytogenetics

❑ Cancer Cytogenetics
❑ Constitutional Cytogenetics

Next-Generation Sequencing Panels

See panel descriptions on back of requisition

❑ Comprehensive Myeloid Sequencing Panel (54 gene profile)
❑ CLL Prognostic Panel (MYD88, SF3B1, TP53, NOTCH1)
❑ Targeted Solid Tumor Panel (15 genes) *[colon, gastric, lung, breast, ovary, melanoma, and prostate diagnosis]*

Individual Molecular Tests

❑ B-Cell Clonality
❑ BCL-1 t(11;14)
❑ BCL-2 t(14;18)
❑ BCR-ABL
❑ BCR-ABL Kinase Domain
❑ BCR-ABL Quantitative
❑ BRAF V600E
❑ CALR
❑ CEBPA
❑ cKIT
❑ EGFR
❑ FLT-3
❑ IgVh Somatic Hypermutation
❑ JAK-2 [V617F]
  ❑ reflex [Exon 12]
  ❑ reflex MPL
❑ JAK-2 [Exon 12]
❑ MPL
❑ MYD88
❑ NPM-1
❑ PML-RARA
❑ T-Cell Clonality
❑ Other: _____
(Choose from molecular menu on back of requisition)

Comments/Requests:
_____
_____

PLEASE CONTACT CLIENT SERVICES AT 877.670.HEME (4363) TO ARRANGE SPECIMEN PICKUP OR ORDER SUPPLIES

OncoMetrix will select the number and type of antibodies, reagents, or probes that are clinically necessary. In keeping with the requirements of Medicare and Medicaid, it is OncoMetrix' policy to only perform testing that is medically necessary for diagnosis and treatment of the patient. Medicare does NOT pay for routine screening tests.

PLEASE SEE REVERSE SIDE FOR OPTIMAL SPECIMEN REQUIREMENTS AND FISH PROBE(S)/PANEL(S).
3495 Hacks Cross Rd. Memphis, TN 38125 877.670.HEME (4363) CLIA 44D0915029

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SPECIMEN LABEL INSTRUCTIONS

1. Complete the requisition with all the requested information **2.** Clearly print patient name on the attached labels.
3. Remove the required number of labels from the front of this page. **4.** Place one (1) label on each container or tube (not on the lid).

PLEASE DISPOSE OF UNUSED LABELS

Name _____ DOB_____ Collection Date _____ ❑ Peripheral Blood ❑ Bone Marrow ❑ Core ❑ Clot Req # here	Name _____ DOB_____ Collection Date _____ ❑ Peripheral Blood ❑ Bone Marrow ❑ Core ❑ Clot Req # here	Name _____ DOB_____ Collection Date _____ ❑ Peripheral Blood ❑ Bone Marrow ❑ Core ❑ Clot Req # here	Name _____ DOB_____ Collection Date _____ ❑ Peripheral Blood ❑ Bone Marrow ❑ Core ❑ Clot Req # here
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