UR MEDICINE | Labs

| # Specimens: | | | Depot: | *STAT* |
|---|---|---|---|---|
| Collect Date: | Time: | By: | ABN Signed: ☐ | |
| MR #: | | A #: | | |

**REQUIRED (PRINT OR PATIENT LABEL)**

Name(Last, First, MI)

Date of Birth | Sex:(circle) M F

Street Address

Street Address 2

City, State, Zip

Phone Number | Client Number

**Indicate primary (1) and secondary (2) insurance**

__Blue Cross/Shield __Child Health Plus __MVP

__Blue Choice __Medicaid __MVPG

_Medicare Blue Choice __Medicare __Aetna

__Other _____

1. Primary Contract #:

Subscriber's Name:

Relationship to Subscriber:

2. Secondary Contract

Subscriber's Name:

Relationship to Subscriber:

Practice Name: _____

Address: _____

_____

City, State, Zip: _____

Phone: _____

Ordering Provider: _____

Phone Results to: Fax Results to:

Ordering Provider's Signature

Date of Signature

Diagnosis Mandatory: Signs/Symptoms or ICD9 Codes

*If ordered for screening, list test name here and write "SCREENING" after it*

Send Additional Reports To: (Full Name/Address)

Compliance is Mandatory and Regulated. For the laboratory to bill properly and receive payment for tests ordered on Medicare Beneficiaries, specific ICD-9 code(s) or a descriptive diagnosis must be included on each patient for each test ordered.It is critical that the diagnosis provided to the lab is consistent with those recorded in the patient medical record on the date of service.

**Clinical History**

## Molecular Diagnostic Laboratory

### Molecular Oncology (No Consent Required)

(Specimen) ☐ Blood ☐ Bone Marrow ☐ Other _____

22939 ☐ IgKappa B cell gene rearrangement (PCR)

36680 ☐ IgH B cell gene rearrangement (PCR)

37343 ☐ T cell receptor gene rearrangement (TCRg)

22220 ☐ bcr - abl (major) RT-PCR t 9;22 ***(Test must be ordered STAT)***

42253 ☐ JAK2 V617F mutation

32206 ☐ FLT - 3 mutation ☐ ITD ☐ Codon 835/836

24710 ☐ NPM1 (nucleophosmin)

CEBN ☐ CEBPA

REFLX ☐ reflex CEBPA if FLT-3 ITD and NPM1 are neg

34682 ☐ MYD88 L265P mutation

### Molecular Genetics (Signed Consent Required)

47831 ☐ Factor V Leiden

23052 ☐ Prothrombin G20210A Mutation

39231 ☐ HFE C282Y, H630, AND S65C Mutations (Hemochromatosis)

30476 ☐ CLN3 Gene Deletion (Batten Disease)

### Chimerism Testing:

Specimen: ☐ Pre-Transplant Patient Specimen ☐ Donor Specimen ☐ Post-Transplant Patient Specimen

☐ Yes ☐ No Has the patient received more than 1 transplant?

☐ Yes ☐ No If this is a Post-Transplant specimen, has the patient been transfused in the last 3 days?

Recipient Name _____

Date of Birth _____

Transplant Date _____

Donor Name/ID _____

Date of Birth _____

Related ☐ Unrelated ☐

## Consent for Molecular Genetic Testing (Required by New York State)

I have read the information on the back of this form and discussed it with my health care provider. I have been given an opportunity to ask questions and have them answered about the tests ordered.

☐ I give my consent for genetic testing, and ☐ I give my consent for the use of remaining sample for research

Patient/Legal Guardian Date: / / Health Care Provider:

# Patient Information Sheet

## Informed Consent for Genetic Testing

1. These tests look for changes in DNA, chromosomes, genes or gene products that are know to be associated with risk of specific diseases. The purpose of these tests is to help your doctor more accurately diagnose your current condition and/or future risk of disease.

2. In addition to assisting in making a diagnosis, these tests may reveal a genetic pre-disposition for one or more of these diseases. You may wish to get genetic counseling before consenting to this test. If a positive result is obtained, additional testing and/or genetic counseling follow-up may be advised.

3. Your doctor has ordered one or more of the following tests:

   FACTOR V LEIDEN - This is a test for a variation in another gene that affects blood clotting. If this variant is present, it may indicated a higher than average risk for developing blood clots.

   PROTHROMBIN GENE MUTATION - This is a test for a variation in another gene that affects blood clotting. If this variant is present, it may indicate a higher than average risk for developing blood clots.

   HEMOCHROMATOSIS MUTATIONS - This is a test for a variation in a gene that controls iron storage in the body, and helps to diagnose hereditary hemochromatosis, a disease of iron overload.

   CLN3 gene deletion - This test detects the most common deletion associated with Batten disease (Juvenile Ceroid Lipofuscinosis). It will help in evaluating the risk of having or being a carrier of this disease. A lack of the mutation does not absolutely rule out the disease, but makes it much less likely.

4. The results of these genetic tests assist in diagnosis, but do not by themselves permit diagnosis of a disease condition. Genetic testing is ordinarily highly accurate; however, in some cases results may not be obtained or may be inconclusive. Only certain variations in these genes are known and available for testing, so a "normal" result in these genetic tests cannot guarantee that you do not have or will not develop a particular disease. Some genetic tests are only done by a few laboratories in the world, and may need to be sent to out of state laboratories that are not certified by New York State Health Department. In some instances, the clinical utility of the test may not be established.

5. Because interpretation of genetic test results is complex, the test results will be provided to your physician who will inform you of the results. To the extent permitted by law, all of the records and results of this testing are confidential and will not be released to anyone other than you, your referring doctors, and Strong Memorial Hospital Medical Records without your consent.

6. Besides providing excellent medical care, one of the missions of the University of Rochester and Strong Memorial Hospital is advancing medical science. Our doctors learn about better ways to care for patients and improve the health of people. No tests other than those authorized will be performed on your sample, and your sample will be destroyed after testing or not more than sixty days after the sample is taken, unless you consent to allow us to use the remaining sample for research. With your consent, our researchers will be able to use the remaining part of blood samples not needed for the specific tests above for approved development of new or improved laboratory tests. Names and other identifying information are kep strictly confidential. Samples with consent for research are stored indefinitely. We sometimes conduct follow-up studies based on new medical information. If you are eligible, someone will contact you personally. Participation in such studies is voluntary.