Molecular Oncology Lab

Phone: 800-245-3117 x6162 | Fax 414-937-6206

NOTE: Versiti does NOT bill patients or insurance. Test orders must be placed through a medical facility that has an account with Versiti. Client # required.

Ordering Institution Information

Person Completing Requisition:	Physician/Provider:	
Institution:		Client #:
Dept:	Address:	
City:	State:	Zip Code:
Phone (Lab):	Provider Contact (phone/email):	
Special Reporting Requests:		PO #:

Is testing for outpatient Medicare enrollee or Wisconsin Medicaid recipient? ☐ Yes ☐ No

If yes, please complete the beneficiary form located at https://versiti.org/products-services/requisitions and submit with this requisition.

Patient Information

Last Name:	First Name:	MI:	DOB:
MR#:	Accession #:	SSN:	

Biologic Sex/Sex Assigned at Birth: ☐ Male ☐ Female ☐Other

Ethnicity: ☐ Ashkenazi Jewish ☐ Black/African American ☐ Central Asian ☐ East Asian ☐ Hispanic/Latino ☐ Middle Eastern ☐ Native American ☐ South Asian ☐ White ☐ Other _____

Specimen Information

Specimen Type: ☐ EDTA WB ☐ EDTA Bone Marrow ☐ Frozen Total RNA ☐ Other _____	Draw Date:	Draw Time:

Patient History

Diagnosis: _____

Is this for disease monitoring?	☐ Yes ☐ No	
Has the BCR-ABL1 fusion been previously detected in this patient?	☐ Yes ☐ No	If yes, please state method: _____

White blood cell count: _____

Testing

☐ BCR-ABL Quantitative Analysis (4502)

☐ BCR-ABL Quantitative Analysis (4502) and BCR-ABL Breakpoint Identification (4504)

VERSITI USE ONLY	
___ EDTA WB ___ EDTA BM ___ Frozen Total RNA ___ Other:_____	
Opened By:	Reviewed By:
Evaluated By:	Labeled By:

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DRAWING INSTRUCTIONS

Tubes must be **individually** labeled with **FULL NAME OF INDIVIDUAL, ANOTHER IDENTIFIER (e.g., SSN, MRN, DOB), DATE AND TIME OF DRAWING**. Samples cannot be accepted after any exposure to an environment in which HLA genes are amplified. This precaution is essential to avoid contamination of samples with DNA that could alter test results. **Samples will be accepted from 8:00 a.m. Monday through noon on Friday**. Emergency testing **MUST** be arranged through the laboratory. Call (414) 937-6201.

TEST	SAMPLE REQUIREMENTS	STORE and SHIP
BCR-ABL Quantitative Analysis	10 mL EDTA (lavender top) whole blood **OR** 3-5 mL bone marrow aspirate	Room temperature via an overnight courier. **Samples must be received within 48 hours of being drawn.**

Verification of Informed Consent

It is recommended that healthcare providers obtain a signed informed consent from the patient when genetic testing is ordered. By signing the informed consent, the patient agrees that that they have received and understand the indications and implications of the genetic test and are voluntarily agreeing to have the test performed. In some states, informed consent is required by existing laws and regulations. Versiti recommends that ordering healthcare providers verify their state laws and regulations regarding informed consent for genetic testing. An informed consent form may be available from your institution, or one can be found at http://www.versiti.org/hg under Forms & Materials. Information regarding a general description of the test, purpose, sensitivity, analytical limitations, and the features and genetics of the condition(s) is also available in the Versiti test catalog.

New York State patients: New York state healthcare providers are required to provide verification that informed consent (complying with New York State Department of Health Genetic Testing Standard 5 [GT S5] and New York State Civil Rights Law, Section 79-l) has been obtained from their patient. For genetic testing to be performed in our laboratory, please sign the verification below or submit a signed informed consent form. The sample will be destroyed not more than 60 days after the sample was obtained, unless a longer period of retention is expressly authorized in the consent.

Verification of Informed Consent: I am a healthcare provider for the patient named on this requisition. I have obtained the required informed consent from the patient or the patient's legal guardian for each genetic test(s) ordered above and I authorize the testing of the enclosed specimen(s). I understand that no tests other than those authorized will be performed on genetic samples.

Signature of healthcare provider _____ Date _____

SHIPPING INFORMATION

Contact laboratory for pediatric drawing requirements or low white cell count drawing requirements. Blood samples should be shipped by overnight carrier. The package must be shipped in compliance with carrier's guidelines. Please contact your carrier for current biohazardous shipping regulations**.**

Label Box: Refrigerate, Room Temperature, or Frozen (whichever is appropriate)

Packages should be addressed to:

Versiti Wisconsin – Molecular Oncology Laboratory
638 N 18th Street
Milwaukee, WI 53233