UR MEDICINE | Labs

# Specimens:		Depot:	
Collect Date:	Time:	By:	ABN Signed: ☐
MR #:		A #:	

STAT

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 | Chart Number

☐ **Registration Information:**

Specialty Billing LAB-BHC

☐ **INSURANCE BILL:**

__Aetna __Medicaid __MVP Gold

__Blue Cross/Shield __Medicare __Other _____

__Blue Choice __MVP

__Blue Choice Medicare

1. Primary Contract #: _____

Subscriber's Name: _____

Relationship to Subscriber: _____

Bassett Medical Center Laboratory **[2BHC]**
1 Atwell Rd
Cooperstown, NY 13326
PHONE: (607) 547-3456 FAX: (607) 547-6717

- ☐ () _____, __.
- ☐ (ANJFC) Allerton, Jeffrey MD
- ☐ (BNE8A) Bravin, Eric MD
- ☐ (CYM8B) Canary, Marcy MD
- ☐ (CNTCA) Chapman, Timothy MD
- ☐ (DTS4A) Davenport, Sa. MD
- ☐ (FKJAA) Fisk, John MD
- ☐ (KTD3B) Knight, Danielle MD
- ☐ (KOE1A) Ko, Edwin MD
- ☐ (PLAFA) Patel, Anush MD
- ☐ (SYS8B) Sastry, Simha MD
- ☐ (SRDXA) Schreiber, Daniel MD
- ☐ (TAV1A) Thirukonda, Venu MD
- ☐ (LEBFA) Lee, Bryan DO
- ☐ (JSP6A) Jacob, Patricia NP
- ☐ (SIV5A) Stabinski, Vi. NP

Phone Results to: Fax Results to:

Ordering Provider's Signature
Date of Signature

Diagnosis Mandatory: Signs/Symptoms or ICD10 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-10 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.

SPECIMEN TYPE SUBMITTED

- ☐ Blood
- ☐ Bone Marrow Aspirate
- ☐ Bone Marrow Core Biopsy
- ☐ Fine Needle Aspirate
- ☐ Needle Core Biopsy. Other Tissue
- ☐ Lymph Node Tissue
- ☐ Spleen Tissue
- ☐ Other Tissue (Type:_____)

STUDIES REQUESTED

Flow Cytometry

- ☐ (18240) Flow Cytometry for lymphoma/leukemia workup
- ☐ (28695) Lymphocyte subset testing (CD4/CD8) (BLOOD ONLY)
- ☐ (29277) CD34 - Stem cell counts
- ☐ (18240) Paroxysmal Nocturnal Hemoglibinuria (PNH) Workup (GPI-linked protein studies) (BLOOD ONLY)

Cytogentics

- ☐ (25789) Chromosome Analysis (Karotype) (BLOOD ONLY)
- ☐ (CYGRN) Bone Marrow Cytogenetics workup

Molecular Diagnostics

- ☐ DNA preparation for Molecular Diagnostic testing

Additional Probes: **(BLOOD ONLY)**

- ☐ (36680) IgKappa B cell gene rearrangement PCR
- ☐ (36680) IgH B cell gene rearrangement IgH IgK
- ☐ (37343) T cell receptor gene rearrangement (TCRg)
- ☐ (22220) bcr-abl (major) RT-PCR t 9;2 (Arup Send Out- must be ordered STAT)
- ☐ (42253) JAK2 V617F mutation
- ☐ (32206) FLT-3 mutation ☐ ITD ☐ Codon 835/836
- ☐ (34682) MYD88 L265P mutation

- ☐ (CHIMR) Chimerism
  - ☐ Pre Transplant
  - ☐ Donor
  - ☐ Recipient
  - ☐ Post Transplant

RELEVANT CLINICAL HISTORY

(Check all that apply)

- ☐ Previous bone marrow biopsies/aspirate, Date(s)_____
- ☐ History of leukemia
- ☐ History of lymphoma
- ☐ History of myeloma (R/O Myeloma)
- ☐ Recent history of growth factor treatment
- ☐ Workup for myelodysplasia
- ☐ Anemia
- ☐ Neutropenia
- ☐ Thrombocytopenia
- ☐ Other Cytopenias

Other relevant Information
(please write below):

_____

_____

_____

_____

**** Please attach Patient clinical history and current CBC findings****

Important Information about Genetic Testing

1. This test will look for changes in the DNA chromosomes, genes, or gene products which are known to be associated with the specific genetic condition in question.

2. This test may reveal that the individual tested is affected with the condition or carries the genetic pre-disposition for it, or that he/she does not. If a positive result is obtained, medical and/or genetic counseling follow-up may be advised.

3. Genetic testing is ordinarily highly accurate, however, in some cases results may not be obtained or may be inconclusive. Also, accurate genetic testing depends upon an accurate diagnosis in affected family members. If the diagnosis in a family is not certain, results can be misleading. I have been able to discuss the expected accuracy of the testing in my particular

4. Some genetic testing may require comparison of samples from multiple family members with their consent, and these cases, previous unknown non-paternity can be discovered.

5. Some genetic tests are only done by a few laboratories in the world, and may need to be sent out of state to laboratories that are not certified by the New York State Health Department.In these cases, approval for testing will be obtained from New York State.

6. Some types of genetic testing such as fluorescence in situ hybridization (FISH) are considered investigational by the New York State Health Department. FISH uses DNA probes which bind to specific regions of the chromosomes, FISH is helpful in identifying the origin of unidentified "marker" chromosomes, unusual variations in chromosome structure or small chromosomal deletions which cannot be seen by standard chromosome testing. FISH may be used, if indicated on my sample. Initial _____

7. Chromosome microarray CGH (Array CGH) test is considered to be investigational by the New York State Department of Health. Micro-array CGH is helpful in detecting chromosomal microimbalances at the DNA level anywhere in the genome. The method uses DNA probes ‘on a chip’ to detect microdeletions or duplications which cannot be seen by standard chromosome and FISH analysis. The purpose of this test is to help your doctor more accurately diagnose genetic abnormalities. Some genetic testing may require array CGH analysis on both parents to determine the nature and origin of certain findings. Array CGH may be used, if indicated, on my sample. Initial : _____

8. Records of this testing or test results will not be released to anyone other than me, my referring doctors and Strong Memorial Medical Records unless I specify otherwise.

9. No tests other than those authorized shall be performed on the biological sample and that the sample shall be destroyed at the end of the testing process or not more than sixty days after the sample was taken. Any part of the biological sample not used for specific genetic testing may be retained and used for medical research as long as names and other identifying information are not revealed. Initial : _____

10. I indicate my desire to opt out of participation in anonymized research studies using my DNA sample by checking this box: ☐

11. The patient is provided with genetic counseling both prior to signing the form and after the array CGH test. Initial of the referring physician or health care provider: _____