

**CYTOGENETICS ONCOLOGY**  
 Referred-in Requisition

Testing is provided for medical purposes only and results are not intended for forensic use. The laboratory is not a forensically accredited laboratory.

SPECIMEN COLLECTION	SPECIMEN TYPE AND INFORMATION
<b>DATE</b> (DD/MM/YYYY)  <b>TIME</b> (HH:MM)	<input type="checkbox"/> <b>Bone marrow aspirate</b> – 3 mLs in sodium heparin tube; transport at room temperature. <input type="checkbox"/> <b>Peripheral blood</b> – 3-6 mLs in sodium heparin tube; transport at room temperature. <input type="checkbox"/> <b>Solid tumour</b> – 2-3 mm <sup>3</sup> fresh tissue in transport medium or sterile PBS. Do not freeze. Transport ASAP. <input type="checkbox"/> <b>Slides with 4 micron FFPE sections</b> (minimum 2 slides, for FISH testing only). Corresponding marked H&E slide requested if selected area to be analyzed. <input type="checkbox"/> <b>FFPE scrolls: 10 X 10 m sections.</b> For OncoScan SNP Microarray testing only. Scrolls can be shipped at room temperature. <input type="checkbox"/> <b>DNA extracted from FFPE tumour tissue.</b> For OncoScan SNP Microarray testing only.  <b>Pathology Case Number</b> - _____
SHIPPING INSTRUCTIONS	
<ul style="list-style-type: none"> <li>Send all specimens to Cytogenetics Laboratory, at the shipping address indicated above</li> <li>After hours, deliver to Rapid Response Laboratory, Room 3642</li> <li>Courier tracking information may be emailed to: <a href="mailto:cytogenetics.requests@sickkids.ca">cytogenetics.requests@sickkids.ca</a></li> </ul>	

INDICATION FOR TESTING	
<b>Haematopoietic</b> <input type="checkbox"/> New Leukemia <input type="checkbox"/> Relapse <input type="checkbox"/> MDS <input type="checkbox"/> End of Induction <input type="checkbox"/> Cytopenia <input type="checkbox"/> Bone marrow involvement <input type="checkbox"/> Follow up <input type="checkbox"/> Anemia <input type="checkbox"/> Other: _____	<b>Solid tumour/lymphoma</b> Tumour type: _____  Site of biopsy: _____

TEST(S) REQUESTED	<input type="checkbox"/> Process and hold pending pathology report/results	<input type="checkbox"/> KARYOTYPE
<b>FISH Leukemia/Lymphoma</b> <b>ALL</b> <input type="checkbox"/> B-ALL FISH panel <input type="checkbox"/> Ph-like (ABL1, ABL2, PDGFRβ) <input type="checkbox"/> Hyperdiploidy FISH probes <input type="checkbox"/> ETV6-RUNX1 (TEL-AML1) <input type="checkbox"/> BCR-ABL1 <input type="checkbox"/> KMT2A (MLL) <input type="checkbox"/> TCF3 (E2A) <input type="checkbox"/> CDKN2A (P16) <input type="checkbox"/> IGH <input type="checkbox"/> CRLF2 <input type="checkbox"/> ZNF384  <b>Myeloproliferative</b> <input type="checkbox"/> BCR-ABL1 <input type="checkbox"/> PDGFRα <input type="checkbox"/> PDGFRβ  <input type="checkbox"/> Other: _____	<b>FISH Solid tumours</b> <b>Aneurysmal bone cyst</b> <b>Nodular fasciitis</b> <input type="checkbox"/> USP6 <b>Alveolar rhabdomyosarcoma</b> <input type="checkbox"/> FOXO1 (FKHR) <b>Dermatofibrosarcoma protuberans</b> <input type="checkbox"/> PDGFB <b>Ewing's tumours</b> <input type="checkbox"/> EWSR1 <b>Infantile fibrosarcoma</b> <input type="checkbox"/> ETV6 <b>Liposarcoma</b> <input type="checkbox"/> DDIT3 (CHOP) <input type="checkbox"/> FUS <b>Neuroblastoma</b> <input type="checkbox"/> MYCN <b>NUTM1-rearranged Neoplasia</b> <input type="checkbox"/> NUTM1 <b>RCC/ASPS/PEComa</b> <input type="checkbox"/> TFE3	<b>Rhabdoid</b> <input type="checkbox"/> INI1 (SMARCB1) <b>Synovial sarcoma</b> <input type="checkbox"/> SS18 (SYT) <b>Undifferentiated sarcoma</b> <input type="checkbox"/> CIC  <b>Nervous system</b> <input type="checkbox"/> ALK <input type="checkbox"/> CDKN2A <b>Astrocytoma</b> <input type="checkbox"/> BRAF <b>Ependymoma</b> <input type="checkbox"/> RELA <b>Medulloblastoma</b> <input type="checkbox"/> MYC <input type="checkbox"/> MYCN <input type="checkbox"/> MYB/CEP6 <b>Oligodendroglioma</b> <input type="checkbox"/> 1p36/1q25 & 19q13/19p13 <b>PNET</b> <input type="checkbox"/> C19MC

Affymetrix OncoScan SNP Microarray  
 Note: For SNP microarray analysis on fresh frozen tissue (CytoScan), please use the SickKids Molecular Pathology requisition.

Referring Physician	Copy of Report
Name (print) _____	Name (print) _____
Address _____	Address _____
Phone _____ Fax _____	
Signature (required) _____	



**CYTOGENETICS LABORATORY**  
 555 University Avenue  
 Room 3416, Hill Wing  
 Toronto, ON, M5G 1X8, Canada  
 Tel: 416-813-7200 x 1  
 Fax: 416-813-7732  
 (CLIA # 99D1014032)

Patient Name:  
 Date of Birth (DD/MM/YYYY):  
 Legal Sex:  Male  Female  Non-binary/U/X  
 Sex Assigned at Birth (if different):  Male  Female  Unassigned  
 Gender Identity (if different):  Male  Female  Non-binary/U/X  
 Parent's Name:  
 Address

MRN#

**CYTOGENETICS ONCOLOGY**

**Billing Form**

At your direction, we will bill the hospital, referring laboratory, referring physician, or a patient/guardian, for the services we render

- Invoices are sent upon completion of each test/service.
- Invoices are itemized and include the date of service, patient name, test name and charge.
- Contact SickKids' Cytogenetics Laboratory at 416-813-7200 x1 with billing inquiries.

**How to complete the Billing Form:**

- Referring physician completes the appropriate section below to specify billing method.
- Send requisition and completed "Billing Form" with specimen.

**Section 1: Complete to have the healthcare provider billed:**

Your Referring Laboratory's Reference #: \_\_\_\_\_

Billing address of hospital, referring laboratory, clinic, referring physician, or medical group: (if different from requisition):

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Prov/State: \_\_\_\_\_  
 Postal/Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

**Section 2: Complete to have patient/guardian billed directly:**

*If you elect to have patient/guardian billed:*

- Patient/Guardian billing information below must be complete; otherwise, the healthcare provider will be billed.
- Please advise the patient/guardian to expect a bill from our laboratory.
- Provide us with patient's valid credit card information.
- Unfortunately, we cannot accept personal checks.
- **In this case, the patient/guardian is solely responsible for the charges.**

**Send bill to** (check one):  Patient  Guardian

**Method of Payment** (check one):  American Express  MasterCard  Visa

Name as it appears on credit card:

Credit card #: \_\_\_\_\_

Expiry date on credit card: \_\_\_\_\_

Signature of credit card holder (Required): \_\_\_\_\_

**Mailing Address of Patient/Guardian (if different from requisition):**  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_ Apt. #: \_\_\_\_\_  
 City: \_\_\_\_\_ Prov/State: \_\_\_\_\_  
 Postal/Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

**Additional Contact Information:**  
 Patient's phone # with area code:  
 \_\_\_\_\_  
 - or -  
 Guardian's phone # with area code:  
 \_\_\_\_\_