THE UNIVERSITY OF TEXAS
MD Anderson ~~Cancer~~ Center
Making Cancer History®

Division of Pathology / Laboratory Medicine
Outreach Services Test Requisition

SHIP FLOW CYTOMETRY AND CYTOGENETICS TESTING TO:
1515 Holcombe Blvd., R4.2317 (Unit 72) Houston, Texas 77030
PHONE: (713) 794-1093 OR 1094
FAX: (713) 745-1994
CONTINENTAL US : 1-800-315-8424

SHIP HLA TESTING ONLY TO :
6565 MD Anderson Blvd., Room Z3.4028
Houston TX 77030
Phone: (713) 792-2658 / Fax: (832) 751-9867

SHIP MOLECULAR TESTING ONLY TO :
6565 MD Anderson Blvd., Room Z3.4023
Houston TX 77030
Phone: (713) 794-4780 / Fax: (713) 563-0031

*Required Fields
PHYSICIAN / FACILITY / CLIENT INFORMATION

*REQUESTING PHYSICIAN ______ *UPIN / NPI NUMBER ______

*PHONE ______ EXT ______ *FAX ______ HOSPITAL / OFFICE ______

ADDRESS ______ CITY ______ STATE ______ ZIP ______

PATIENT INFORMATION

LAST NAME ______ FIRST NAME ______ DOB ______ SEX ______

ID NUMBER ______ PT. PHONE ______ SSN ______

PT. ADDRESS ______ CITY ______ STATE ______ ZIP ______

INSURANCE PROVIDER ______ POLICY NUMBER ______ PHONE NUMBER ______

SPECIMEN INFORMATION: Collection Date: _______/______/_______ Time: _________ A / P
Specimen Type: Serum ☐ Plasma ☐ BM ☐ Urine ☐ PB ☐ Other______________________________
Diagnosis:______________________________

MICROBIOLOGY

☐ CMV Antigenemia
☐ Glactomanan (Aspergillus Ag)

MOLECULAR DIAGNOSTICS

NOTE: Next Generation Sequencing (NGS) based mutigene panels are NOT available for non-MD Anderson Patients

Leukemia/Lymphoma Testing with Interp and Report

Translocation/Gene Fusions

☐ t(9;22)/*BCR::ABL1*_Major transcript((e13a2(b2a2), (e14a2(b3a2); p210)(quantitative PCR) with interp and report
☐ t(9;22)/*BCR::ABL1*_Minor transcript (e1a2; p190) (quantitative PCR)) with interp and report
☐ *BCR::ABL1* t(9;22)_Alternative Transcript (e13a2(b2a2), e14a2(b3a2), e1a2, e13 a3(b2a3), e14a3(b3a3) ,e1a3) (qualitative PCR) with interp and report
☐ *FIP1L1::PDGFRA* Fusion Detection (qualitative PCR) with interp and report

Stem Cell Transplant Studies with Interp and Report

☐ Post-Transplant Quantitative Chimerism Analysis:
☐ Myeloid cells (available for peripheral blood only)
☐ T-cells (available for peripheral blood only)

CYTOGENOMICS

☐ Conventional chromosome analysis
☐ Fluresence in stu hybridization (FISH)
☐ Specify Probe ________________

FLOW CYTOMETRY

☐ Acute Leukemia Screen Panel
☐ AML MRD
☐ B ALL MRD
☐ BCMA
☐ B-CLL/B-Cell Lymphoma Panel
☐ BPDCN
☐ CD4/CD8 ratio (PB only)
☐ CD34 Assay
☐ CLL MRD
☐ Hairy Cell Leukemia Panel
☐ Immunodeficiency Panel
☐ IR panel
☐ Limited B-CLL Panel (CD5/CD19/CD38, kappa, lambda)
☐ Lymphocyte Subset
☐ Mastocytosis
☐ MDS
☐ MM MRD
☐ Myeloma Panel
☐ PNH
☐ T ALL MRD
☐ T-Cell Lymphoma/Mycosis Fungoides (MF) panel
☐ Transplant Panel
☐ Waldenstrom's Panel
☐ Other Markers Please specify: ______________________

HISTOCOMPATIBILITY – HLA

PATIENT TYPING

☐ HLA – Class I, Molecular [2L]
☐ HLA – Class II, Molecular [2L]
☐ Platelet Antibody
☐ Other ________________

DONOR TYPING

☐ HLA Class I Molecular
☐ HLA Class II Molecular

DONOR INFORMATION

Last Name: ______________________ First Name: _________________
DOB: ________ Sex: ________ Race: ________ Legal ID# (DL, SSN or passport):______________________
Relationship to Patient : ________________________

COMMENTS

Additional information for molecular test, refer to website
https://www.mdanderson.org/research/research-resources/core-facilities/molecular-diagnostics-lab/how-to-submit-a-sample.html

DISCLOSURE

Disclosure of your social security number (SSN) is requested from you in order for The University of Texas M.D. Anderson Cancer Center to process your request for diagnostic services. No statute or other authority requires that you disclose your SSN for this purpose and we may not deny services if you choose not to disclose it. Failure to provide your SSN, however, may result in the creation of a duplicate patient number being issued, which may lead to multiple medical records. Further disclosure of your SSN is governed by the Texas Public Information Act and other applicable law.
For questions related to the above information call at (800) 315-8424 or Fax (713) 745-1994.

U.T. M.D. ANDERSON CANCER CENTER
DIVISION OF PATHOLOGY AND LABORATORY MEDICINE
ADMISSIONS AND NEW PATIENT REGISTRATION

Blood _______
Tissue _______
Slides _______

MR #______________

REGISTRATION REQUEST

1. PATIENT INFORMATION

PATIENT NAME: ____________________

PATIENT'S ADDRESS: ____________________

____

PATIENT'S PHONE: ____________________

PATIENT'S DATE OF BIRTH: ____________________

PATIENT'S SOCIAL SECURITY #: ____________________

PATIENT'S SEX: ___________ PATIENT'S MARITAL STATUS: ____________________

2. PRIMARY INSURANCE *will fax face sheet if secondary insurance is listed ___________

INSURANCE COMPANY: ____________________

POLICY #: ____________________

ADDRESS: ____________________ TELEPHONE#: ____________________
____________________ EFFECTIVE DATE: ____________________

GROUP PLAN NAME: ____________________ GROUP PLAN #: ____________________

INSURED'S NAME (if different from patient): ____________________

RELATIONSHIP TO PATIENT: ____________________

INSURED'S SS#: ____________________

INSURED'S DOB: ____________________

3. GUARANTOR INFORMATION

SELF: ____________________
OTHER: (NAME) ____________________
(ADDRESS) ____________________
____
____
(PHONE) ____________________

4. MDACC SERVICE CODE: ____________________
MDACC PHYSICIAN CODE: ____________________

5. CONSULT REQUESTED BY: ____________________
PH# : ____________________

Disclosure of your social security number (SSN) is requested from you in order for The University of Texas M.D. Anderson Cancer Center to process your request for diagnostic services. No statute or other authority requires that you disclose your SSN for this purpose and we may not deny services if you choose not to disclose it. Failure to provide your SSN, however, may result in the creation of a duplicate patient number being issued, which may lead to multiple medical records. Further disclosure of your SSN is governed by the Texas Public Information Act and other applicable law.

For questions related to the above information call at (800) 315-8424 or Fax (713) 745-1994.

(Instructions for Flow Cytometry Testing)

UTMDACC
Clinical Flow Cytometry

INSTRUCTIONS FOR COLLECTION AND SHIPMENT OF PATIENT SPECIMEN FOR FLOW CYTOMETRY TESTING

For **Bone Marrow Collection**: Draw 1-3cc of bone marrow in 10 ml EDTA Tube.

For **Peripheral Blood Collection**: Draw 10 ml of venous peripheral blood, using 10 ml EDTA Tube.

Label tubes with the following:

- **Patient's full name**
- **Date of Birth**
- **Patient's UTMDACC Number (if registered through Outreach Department 1-800-315-8424)**
- **Date and Time of Collection**
- **Initials of Phlebotomist**
  CBC Differential
- **Diagnosis if known**

Package tubes and requisition form in a suitable mailer, on a cold pack, and ship both to UTMDACC, Laboratory (at address below). Customer/Sender must pay for shipping. Ship via Overnight Delivery Service.

Please note that the laboratory is **open 24hours Monday through Friday**. We will not accept delivery on weekends, or holidays or after 6PM on Friday. Therefore, coordinate specimen collection and shipping within these days and times.
Please contact us if you have any question regarding these instructions.

Telephone 713-794-4639
Email: FLOWLOG@mdanderson.org

Request for **Flow Cytometry Testing only** should be sent to:
6565 MD Anderson Blvd. Room Z5. 4027
Houston, Texas 77030
Phone # 713 794 4639
Please overnight delivery by UPS, DHL and FedEx
email tracking number to FLOWLOG@mdanderson.org

(Instructions for Cytogenetics Testing)

UTMDACC
Cytogenetics Laboratory
6565 MD Anderson Blvd., Room Z5.4000
Houston, Texas 77030

INSTRUCTIONS FOR COLLECTION AND SHIPMENT OF PATIENT SPECIMEN FOR CYTOGENETICS TESTING

For **Bone Marrow Collection:** Draw 1-2cc of bone marrow in sodium heparin.

For **Peripheral Blood Collection:** Draw 10-20 ml of venous peripheral blood, using sterile sodium heparin tube (green top).

Label tubes with the following:

- **Patient's full name**
- **Date of Birth**
- **Patient's UTMDACC Number (if registered through Outreach Department 1-800-315-8424)**
- **Date and Time of Collection**
- **Initials of Phlebotomist**
  CBC Differential
- **Diagnosis if known**

Package tubes and requisition form in a suitable mailer, on a cold pack, and ship both back to UTMDACC, Cytogenetics Laboratory (at address above), using AIRBONE Shipping (Customer/Sender must pay for shipping). Ship via AIRBORNE'S Overnight Delivery Service.

Please note that the laboratory is **open Monday through Friday 7:00am-11pm only.** We will not accept delivery on weekends, or holidays. Therefore, coordinate specimen collection and shipping within these days and times.
Please contact us if you have any question regarding these instructions.

Telephone:713-792-6330
FAX: 713-745-3215

Request for **Cytogenetics Testing only** should be sent to:

6565 MD Anderson Blvd. Room Z5. 4027
Houston, Texas 77030
Phone # 713 794 4639

(Instructions for HLA Testing)

UTMDACC
Histocompatibility Laboratory
6565 MD Anderson Blvd., Room Z3.4028,
Houston, Texas 77030

INSTRUCTIONS FOR COLLECTION AND SHIPMENT OF PATIENT SPECIMEN FOR HLA TESTING

For **Peripheral Blood Collection**: Draw venous peripheral blood, using sterile (2) 10 ml EDTA tubes for HLA Testing.

For **Patient's Only:** Draw above tubes and include an additional (1) 7 ml red top for Antibody Testing (if needed)

Label tubes with the following:

- **Patient's full name**
- **Date of Birth**
- **Patient's UTMDACC Number (if registered through Outreach Department 1-800-315- 8424)**
- **Date and Time of Collection**
- **Initials of Phlebotomist**

Package tubes and requisition form in a suitable mailer, at room temperature, and ship both back to UTMDACC, HLA Laboratory (at address above), using UPS Shipping (Customer/Sender must pay for shipping). Ship via UPS' Overnight Delivery Service. Please note that the laboratory is **open Monday through Friday 7:30 am - 7:30 pm only**. We will not accept delivery on weekends, or holidays. Therefore, coordinate specimen collection and shipping within these days and times.

Please contact us if you have any question regarding these instructions.

Telephone: 713-792-2658
FAX: 832-751-9867

Request for **HLA Testing Only** should be sent to:

UT M. D. ANDERSON CANCER CENTER
Histocompatibility Laboratory
6565 MD Anderson Blvd., Room Z3.4028,
Houston, Texas 77030

(Instructions for Molecular Testing)

UTMDACC
Molecular Diagnostics Laboratory
6565 MD Anderson Blvd, Room Z3.4023
Houston, Texas 77030

Collection and Transport of Specimens for Molecular Testing

To ensure optimum testing conditions for a specimen that is sent to the Molecular Diagnostics Laboratory (MDL) at MD Anderson Cancer Center (MDACC), the client should follow the below guidelines:

1. For **Peripheral Blood,** collect one 10 ml venous blood in EDTA (purple-top) vacutainer tubes.

For **Bone Marrow,** collect 1-3 ml in EDTA. *It is important that* a non-heparinized syringe is used for the initial bone marrow collection; then transferring the specimen to the sterile EDTA vacutainer tube **without using a needle to dispense the sample.** **All bone marrow specimens must be accompanied with a BM Differential or pathology report.**

Chimerism Analysis Requirement:

1. Donor specimen: Whole blood minimum 2 ML EDTA or extracted DNA 50 ng/uL. Please include donor identifier, date and time of collection. This is required to establish donor microsatellite pattern at the time of first request only. Not needed for subsequent requests.
2. Pre-transplant recipient specimen: Whole blood or bone marrow aspirate, minimum 2 mL in EDTA tube or extracted DNA minimum 50 ng/uL. This is required to establish recipient pre-transplant microsatellite pattern at the time of first request only. Not needed for subsequent requests. Please include date and time of collection.
3. Post-transplant recipient specimen:
   a. Total chimerism: Whole blood or bone marrow aspirate, minimum 2 mL in EDTA tube
   b. T-cells and myeloid-cells chimerism: Whole blood, 10 ml in EDTA tube for T-cell and myeloid cell enrichment

2. Identify the specimen(s) to be sent to MDL:
   - Patient's full name
   - Date of Birth(DOB)
   - Patient's MDACC# (if available)
   - Date and Time of Collection
   - Initials of Phlebotomist.

3. All EDTA tubes should be refrigerated immediately after collection and **shipped with cold pack** by overnight courier. Specimen types such as cDNA, genomic DNA and/or RNA can be used directly for testing only if extraction or isolation is performed in a CLIA-certified lab. These should be shipped on dry ice for optimal preservation.

4. Samples should be shipped by overnight carrier to arrive Tuesday- Friday by 4:00PM. Call **713-794-4780** for additional information.

Sender is responsible for shipping charges.

Shipping Address: **UTMDACC**
Molecular Diagnostics Laboratory
6565 MD Anderson Blvd., Room Z3.4023
Houston, Texas 77030