MOLECULAR DIAGNOSTIC LABORATORY
Barnes-Jewish Hospital, Institute of Health
425 South Euclid Avenue
Room 5970, Mailstop #90-28-344
St. Louis, MO 63110
(314) 454-8685, 314-454-7601; FAX (314) 454-7616
URL: http://pathology.wustl.edu/patientcare/moldiagnostic.php

BARNES-JEWISH Hospital
BJC HealthCare

Request For DNA Studies
ONCOLOGY

COLLECTION INFORMATION: ☐ AM ☐ PM
DATE _____ TIME _____ INITIALS _____

ACCOUNT INFORMATION

NAME

ADDRESS

CITY STATE ZIP
PHONE

FAX

ORDERING PHYSICIAN

SECOND REPORT TO

ACCOUNT	PATIENT ACCT.	RESEARCH ACCT.

PATIENT INFORMATION

PATIENT LAST NAME OR ID# FIRST			DOB	SEX
RACE (see back)	ETHNICITY (see back)	DIAGNOSIS CODE	SSN	
PATIENT'S ADDRESS CITY STATE ZIP			PHONE	

BILLING INFORMATION } **BILL TO:** ☐ ACCOUNT ☐ PATIENT ☐ INSURANCE ☐ RESEARCH ACCT.

☐ Medicare ☐ Medicaid ☐ CARE PARTNERS ☐ PARTNERS HMO
ID # ALPHA Code _____ ☐ GHP ☐ OTHER _____

INSURANCE CO.	I.D. #
ADDRESS	GRP. #
INSURED NAME (IF NOT PATIENT)	PLAN NAME
PATIENT ID }	NO. SPEC RECEIVED }
REGISTERED BY }	VERIFIED BY }

NOTE TO PHYSICIAN: When seeking payment from Medicare or Medicaid, Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient, for instance, Medicare does not cover routine screening, testing that is "investigative" or research use only, testing with quantity limits.

Laboratory Use Only:

Specimen Condition: _____

Specimen Number: _____

Date Received: _____

Time Received: _____

☐ Patient ☐ Donor for: _____
☐ Pre-BMT ☐ Post-BMT
☐ Allogenic ☐ Autologous

Sample Type:
☐ BM
☐ PB Whole
☐ PB T Lymphocytes
☐ PB Myeloid cells
☐ Lymph node
☐ Other: _____

Tube Type:
☐ Sodium EDTA
☐ ACD
☐ Paraffin Embedded
☐ Frozen
☐ Other: _____

☐ BCR/ABL Quant.
☐ IGH Hypermutation (IGHV)
☐ IGH Rearrangement (B cell Clonality)
☐ JAK2 Quant.
☐ NPM1
☐ PML-RARα (t(15;17)) Qualitative
☐ STR Comprehensive testing (Patient Pre-BMT)
☐ STR Identity testing
☐ STR Donor testing (Donor Pre-BMT)
☐ STR Separated PB Cells (Enrichment), 3mL per cell type
☐ CD3 ☐ CD19
☐ CD15 ☐ CD56

☐ TCR Gamma Rearrangement
☐ UGT1A1
☐ AML Diagnostic/Risk Stratification Panel (PML/RARA, FLT3, NPM1, DNMT3A, IDH1, IDH2, KIT, CEBPA per algorithm)
☐ MPN Diagnostic/Risk Stratification Panel (BCR/ABL, JAK2, CALR, CSF3R)
☐ Other (Prior Lab approval req'd)

Clinical Information:

Studies cannot be completed without adequate patient identification and requested clinical information.

Patient Demographic Information:

Race:	American Indian or Alaska Native	AI
	Asian	AS
	Black or African American	BL
	Native Hawaiian or other Pacific Islander	PI
	White	WH
	Unknown	UN
	Some other Race	SR
Ethnicity:	Hispanic or Latino	002
	Non Hispanic or Latino	003
	Unknown	004

MOLECULAR DIAGNOSTIC LABORATORY
Barnes-Jewish Hospital, Institute of Health
425 South Euclid Avenue
Room 5970, Mailstop #90-28-344
St. Louis, MO 63110
(314) 454-8685, 314-454-7601; FAX (314) 454-7616
URL: http://pathology.wustl.edu/patientcare/moldiagnostic.php

BARNES-JEWISH Hospital
BJC HealthCare

Request For DNA Studies
ONCOLOGY

COLLECTION INFORMATION: ☐ AM ☐ PM
DATE _____ TIME _____ INITIALS _____

ACCOUNT INFORMATION

NAME

ADDRESS

CITY STATE ZIP
PHONE

FAX

ORDERING PHYSICIAN

SECOND REPORT TO

ACCOUNT	PATIENT ACCT.	RESEARCH ACCT.

PATIENT INFORMATION

PATIENT LAST NAME OR ID# FIRST			DOB	SEX
RACE (see back)	ETHNICITY (see back)	DIAGNOSIS CODE	SSN	
PATIENT'S ADDRESS CITY STATE ZIP			PHONE	

BILLING INFORMATION } **BILL TO:** ☐ ACCOUNT ☐ PATIENT ☐ INSURANCE ☐ RESEARCH ACCT.

☐ Medicare ☐ Medicaid ☐ CARE PARTNERS ☐ PARTNERS HMO
ID # ALPHA Code _____ ☐ GHP ☐ OTHER _____

INSURANCE CO.	I.D. #
ADDRESS	GRP. #
INSURED NAME (IF NOT PATIENT)	PLAN NAME
PATIENT ID }	NO. SPEC RECEIVED }
REGISTERED BY }	VERIFIED BY }

NOTE TO PHYSICIAN: When seeking payment from Medicare or Medicaid, Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient, for instance, Medicare does not cover routine screening, testing that is "investigative" or research use only, testing with quantity limits.

Laboratory Use Only:

Specimen Condition: _____

Specimen Number: _____

Date Received: _____

Time Received: _____

☐ Patient ☐ Donor for: _____
☐ Pre-BMT ☐ Post-BMT
☐ Allogenic ☐ Autologous

Sample Type:
☐ BM
☐ PB Whole
☐ PB T Lymphocytes
☐ PB Myeloid cells
☐ Lymph node
☐ Other: _____

Tube Type:
☐ Sodium EDTA
☐ ACD
☐ Paraffin Embedded
☐ Frozen
☐ Other: _____

☐ BCR/ABL Quant.
☐ IGH Hypermutation (IGHV)
☐ IGH Rearrangement (B cell Clonality)
☐ JAK2 Quant.
☐ NPM1
☐ PML-RARα (t(15;17)) Qualitative
☐ STR Comprehensive testing (Patient Pre-BMT)
☐ STR Identity testing
☐ STR Donor testing (Donor Pre-BMT)
☐ STR Separated PB Cells (Enrichment), 3mL per cell type
☐ CD3 ☐ CD19
☐ CD15 ☐ CD56

☐ TCR Gamma Rearrangement
☐ UGT1A1
☐ AML Diagnostic/Risk Stratification Panel (PML/RARA, FLT3, NPM1, DNMT3A, IDH1, IDH2, KIT, CEBPA per algorithm)
☐ MPN Diagnostic/Risk Stratification Panel (BCR/ABL, JAK2, CALR, CSF3R)
☐ Other (Prior Lab approval req'd)

Clinical Information:

Studies cannot be completed without adequate patient identification and requested clinical information.

Patient Demographic Information:

Race:	American Indian or Alaska Native	AI
	Asian	AS
	Black or African American	BL
	Native Hawaiian or other Pacific Islander	PI
	White	WH
	Unknown	UN
	Some other Race	SR
Ethnicity:	Hispanic or Latino	002
	Non Hispanic or Latino	003
	Unknown	004