BAYLOR GENETICS
READY WITH ANSWERS

SHIPPING Baylor Genetics
2450 Holcombe Blvd., Grand Blvd. Receiving Dock
Houston, TX 77021-2024
Phone: 713.798.6555
Fax: 713.798.2787

TUMOR ANALYSIS REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM/DD/YYYY)

Address | Accession # | Hospital/ Medical Record #

Biological Sex: ◯ M ◯ F ◯ Unknown

City | State | Zip | Phone | Gender identity (if different from above):

REPORTING RECIPIENTS

Ordering Physician | Institution Name

Email (Required for International Clients) | Phone | Fax

◆ **ADDITIONAL RECIPIENTS**

Name | Name

Email | Fax | Email | Fax

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

☐ **SELF PAYMENT**

◯ Bill Patient For Laboratory Testing

☐ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

☐ **INSURANCE**

☐ Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS
1. Copy of the Front/Back of Insurance Card(s)
2. ICD10 Diagnosis Code(s)
3. Name of Ordering Physician
4. Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM/DD/YYYY) | Address of Insured

Patient's Relationship to Insured | Phone of Insured | City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone | Primary Member Policy # | Primary Member Group #

Name of Insured | Insured Date of Birth (MM/DD/YYYY) | Address of Insured

Patient's Relationship to Insured | Phone of Insured | City | State | Zip

Secondary Insurance Co. Name | Secondary Insurance Co. Phone | Secondary Member Policy # | Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my designated insurance carrier any information necessary, including test results, for processing my insurance claim. I also authorize benefits to be payable exclusively to Baylor Genetics. I understand that my insurance carrier may not approve or reimburse my medical genetic services in full or any portion thereof, due to a variety of reasons, including, but not limited to: the contract status of my insurance provider with Baylor Genetics, usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. I understand that I am responsible for any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Name | Patient's Signature | Date (MM/DD/YYYY)

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name | Physician's Signature | Date (MM/DD/YYYY)

BAYLOR GENETICS
READY WITH ANSWERS

SHIPPING Baylor Genetics
2450 Holcombe Blvd., Grand Blvd. Receiving Dock
Houston, TX 77021-2024
Phone: 713.798.6555
Fax: 713.798.2787

TUMOR ANALYSIS REQUISITION

Patient Last Name _____ Patient First Name _____ MI _____ Date of Birth (MM/DD/YYYY) ___/___/___ Biological Sex _____

ETHNICITY

- ◯ African American
- ◯ Ashkenazi Jewish
- ◯ East Asian (China, Japan, Korea)
- ◯ Finnish
- ◯ French Canadian
- ◯ Hispanic American
- ◯ Mennonite
- ◯ Middle Eastern (Saudi Arabia, Qatar, Iraq, Turkey)
- ◯ Native American
- ◯ Northern European Caucasian (Scandinavian, UK, Germany)
- ◯ Pacific Islander (Philippines, Micronesia, Malaysia, Indonesia)
- ◯ South Asian (India, Pakistan)
- ◯ Southeast Asian (Vietnam, Cambodia, Thailand)
- ◯ Southern European Caucasian (Spain, Italy, Greece)
- ◯ Other (Specify) _____

SAMPLE INFORMATION

Date of Collection (MM/DD/YYYY) ___/___/___

Time of Collection (HH:MM) _____

◆ **REQUIRED FOR BREAST CANCER & FFPE SAMPLES**

Method of Fixation _____

Time to Tissue Fixation _____

Tissue Fixation Time _____

◆ **SAMPLE TYPE**

- ◯ Blood in EDTA Tube (Purple-Top) +
- ◯ Blood in Sodium Heparin (Green-Top) +
- ◯ Bone Core (Fresh) +
- ◯ Bone Marrow in Sodium Heparin (Green-Top) +
- ◯ Bone Marrow in EDTA (Purple-Top) +
- ◯ FFPE - Slides * #: _____
- ◯ FFPE - Tissue Block *
- ◯ Tissue (Fresh/Fresh Frozen) *
- ◯ DNA (Concentration) +*: _____
- ◯ RNA (Concentration) +*: _____
- ◯ Other **: _____

WBC Count _____ Percent Blasts _____ Gender of BMT Donor (Select one): ◯ M ◯ F

+ For hematologic samples, attach clinical notes and pathology reports, if available.

* Surgical pathology report MUST be attached for all tissue samples.

** Please call for consultation before ordering test.

INDICATION FOR TESTING (REQUIRED)

- ◯ Breast Cancer
- ◯ Colorectal Cancer
- ◯ Lung Cancer
- ◯ Ovarian Cancer
- ◯ Acute Myeloid Leukemia
- ◯ Chronic Lymphocytic Leukemia
- ◯ Chronic Myelogenous Leukemia
- ◯ Myelodysplastic Syndrome
- ◯ Melanoma
- ◯ Myeloproliferative Neoplasm
- ◯ Acute Lymphoblastic Leukemia
- ◯ Other (Specify): _____
- ◯ Non-Hodgkin Lymphoma
- ◯ Plasma Cell Neoplasm

If above checked, specify subtype, if applicable: _____

ICD10 Diagnosis Code(s): _____

RETURN OF FFPE SPECIMENS

☐ Check if block and/or H&E stained slide should be returned. Fill out the return address information below, or affix preprinted label.

This section will be used as the return address label.

Institution: _____ ATTN: _____

Address: _____

SPECIMEN RETRIEVAL

☐ I want Baylor Genetics to return the specimen. (Complete information below)

Location of Specimen: _____

Contact Name: _____

Phone #: _____ Fax #: _____

BAYLOR GENETICS
READY WITH ANSWERS

SHIPPING Baylor Genetics
2450 Holcombe Blvd., Grand Blvd. Receiving Dock
Houston, TX 77021-2024
Phone: 713.798.6555
Fax: 713.798.2787

TUMOR ANALYSIS REQUISITION

Patient Last Name | Patient First Name | MI | Date of Birth (MM/DD/YYYY) | Biological Sex

CANCER MOLECULAR ANALYSIS

BE = Blood in EDTA (purple-top); **BME** = Bone Marrow in EDTA (purple-top);
FFPE = Slides/Block; **T** = Fresh/Frozen Tissue

NOTE: For Molecular Tests, Bone Marrow and Blood are REQUIRED to be collected in EDTA (PURPLE-TOP) TUBES

◆ HEMATOLOGIC MALIGNANCIES

TEST CODE	TEST NAME	SAMPLE TYPE
☐ 9715	Hematologic Malignancy Mutation Panel	BE, BME, FFPE, T
☐ 9515	CytoScan HD SNP Array	BE, BME, T

◆ SOLID TUMORS

TEST CODE	TEST NAME	SAMPLE TYPE
☐ 9705	Solid Tumor Mutation Panel	BE, FFPE, T
☐ 9505	180K CGH/SNP Array [1]	BE, BME, FFPE, T

◆ SINGLE GENE TESTING

All single gene tests will be sent out to ARUP Laboratories for analysis and reporting unless otherwise noted.

TEST CODE	TEST NAME	SAMPLE TYPE
☐ 9202	B-Cell Clonality Screening (IgH and IgK) by PCR	BE, BME, FFPE, T
☐ 9065	*BCR-ABL1*, Major (p210), Quantitative	BE, BME
☐ 9070	*BCR-ABL1*, Qualitative Analysis w/ Reflex to *BCR-ABL1* Quantitative	BE, BME
☐ 9305	*BCR-ABL1* Mutation Analysis for Tyrosine Kinase Inhibitor Resistance by NGS	BE, BME
☐ 9003	*BRAF* V600 Mutation Analysis	BE, BME, FFPE
☐ 9016	*CALR* (Calreticulin) Exon 9 Mutation Analysis by PCR	BE, BME
☐ 9086	*CEBPA* Mutation Detection	BE, BME
☐ 9030	*EGFR* Mutation Detection by Pyrosequencing	FFPE
☐ 9045	*FLT3* Mutation Detection by PCR [2]	BE, BME
☐ 9104	Gastrointestinal Stromal Tumor Mutation (*KIT*, *PDGFRA*)	FFPE
☐ 9060	*IGHV* Mutation Analysis by Sequencing	BE, BME
☐ 9015	*JAK2* Exon 12 Mutation Analysis by PCR	BE, BME
☐ 9010	*JAK2* Gene, V617F Mutation, Qualitative	BE, BME
☐ 9103	*KIT* Mutations, Melanoma (including *PDGFRA*)	FFPE
☐ 9105	*KIT* Mutations in AML by Fragment Analysis and Sequencing	BE, BME
☐ 9128	*KRAS* Mutation Detection	FFPE
☐ 9150	Microsatellite Instability (MSI), HNPCC/Lynch Syndrome, by PCR [3]	FFPE
☐ 9020	*MPL* Codon 515 Mutation Detection by Pyrosequencing, Quantitative	BE, BME
☐ 9005	*NPM1* Mutation by PCR and Fragment Analysis	BE, BME, FFPE
☐ 9035	*PIK3CA* Mutation Detection	FFPE
☐ 9080	*PML-RARA* Translocation, t(15;17) by RT-PCR, Quantitative	BE, BME
☐ 9217	T-Cell Clonality Screening by PCR	BE, BME, FFPE, T
☐ 9055	*TP53* Somatic Mutation, Prognostic	BE, BME, FFPE

◆ REFLEX TESTS

Reflex Request (Please describe below):

[1] For test code 9505: If sending FFPE slides, 20 slides are required for submission.
[2] For test code 9045: Test will be sent to LabPMM for analysis and reporting.
[3] For test code 9150: Please submit BOTH a source of tumor tissue (FFPE block/slides) AND a source of normal tissue (FFPE block/slides).

Cytogenetic testing options on next page

BAYLOR GENETICS
READY WITH ANSWERS

SHIPPING Baylor Genetics
2450 Holcombe Blvd., Grand Blvd. Receiving Dock
Houston, TX 77021-2024
Phone: 713.798.6555
Fax: 713.798.2787

TUMOR ANALYSIS REQUISITION

Patient Last Name | Patient First Name | MI | Date of Birth (MM/DD/YYYY) | Biological Sex

CYTOGENETIC TESTS

BH = Blood in Sodium Heparin (green-top); **BMH** = Bone Marrow in Sodium Heparin (green-top); **TM** = Tissue in Medium

NOTE: Bone Marrow and Blood are REQUIRED to be collected in SODIUM HEPARIN (GREEN-TOP) TUBES

◆ CLASSICAL CHROMOSOME ANALYSIS

TEST CODE	TEST NAME	SAMPLE TYPE
☐ 8300	Hematologic Cancer	BH, BMH
☐ 8050	Solid Tumor	TM

◆ FISH PANELS

TEST CODE	TEST NAME	SAMPLE TYPE	TEST CODE	TEST NAME	SAMPLE TYPE
☐ 8010	ALL (MYB del, CDKN2A del, BCR/ABL, TEL/AML1, MLL rearrangement, IGH rearrangement)	BH, BMH	☐ 8005	MDS (5 del, 7 del, Trisomy 8, MLL rearrangement, 20q del)	BH, BMH
☐ 8000	AML (Trisomy 8, AML/ETO, MLL rearrangement, PML/RARA, CBFB inversion)	BH, BMH	☐ 8015	Multiple Myeloma (Trisomy 9, RB1 del, IGH rearrangement, Trisomy 15, p53 del)	BH, BMH
☐ 8040	CLL (MYB del, ATM del, Trisomy 12, 13 del, p53 del, IGH rearrangement)	BH, BMH	☐ 8020	NHL (ALK rearrangement, BCL-6 rearrangement, ATM & p53 del, IGH rearrangement)	BH, BMH

◆ SINGLE FISH PROBES

TEST CODE	TEST NAME
☐ 8055	1p/19q Co-deletion
☐ 8030	ALK Rearrangement
☐ 8725	AML1/ETO: t(8;21) [AML]
☐ 8775	BCL6 Rearrangement
☐ 8750	BCR/ABL: t(9;22) [CML/ALL/AML]
☐ 8740	CBFB: inv(16) [AML]
☐ 8730	CHIC2: Deleted 4q [Hypereosinophilic Syndrome]
☐ 8710	Deletion 5: [MDS]
☐ 8715	Deletion 7: [MDS]
☐ 8720	Deletion 20q12: [MDS]
☐ 8065	DXZ1/DYZ3
☐ 8035	EGFR
☐ 8025	ERBB2 (HER2/neu)
☐ 8385	Gain Chromosome 8

TEST CODE	TEST NAME
☐ 8780	IGH Rearrangement
☐ 8765	IGH/BCL2: t(14;18) [Follicular Lymphoma]
☐ 8770	IGH/CCND1: t(11;14) [Mantle Cell Lymphoma]
☐ 8095	MET Amplification
☐ 8745	MLL: 11q23
☐ 8760	MYC translocation
☐ 8735	PML/RARA: t(15;17) [AML]
☐ 8031	RET Rearrangement
☐ 8781	ROS1 Rearrangement
☐ 8075	SS18 [Synovial Sarcoma]
☐ 8080	TCF3/PBX1 [ALL]
☐ 8755	TEL/AML1: t(12;21) [ALL]
☐ 8400	OTHER, Probe Name: