



PROPATH
A Sonic Healthcare Anatomic Pathology Practice

1355 RIVER BEND DRIVE
DALLAS, TX 75247
P 214.638.2000
P 800.258.1253
F 214.237.1731
www.ProPath.com

REFERRED

PATIENT INFORMATION - PLEASE PRINT: PATIENT NAME (LAST) (FIRST) (M.I.)

ADDRESS APT#

CITY STATE ZIP

(AREA CODE) PHONE BIRTH DATE SEX

PATIENT S.S. # PATIENT I.D.#

BILL TO: Account Patient (Self Pay) Medicare Medicaid
Insurance *Please submit a copy of ID card (front and back)
Inpatient (Discharge Date) Outpatient

PLEASE NOTE: Technical Component of services for Hospital-registered Medicare, Medicaid, and Tricare patients will be billed to the Hospital

INSURANCE COMPANY NAME (attach card) EMPLOYER NAME

NAME OF INSURED POLICY / MEMBER ID # GROUP #

RELATIONSHIP TO INSURED: SELF SPOUSE DEPENDENT

MAIL CLAIM TO

ADDRESS

CITY/STATE/ZIP

PHYSICIAN ACKNOWLEDGEMENT (Required)

Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient. Medicare Patients: The Advance Beneficiary Notice, if required, must be completed, signed by the patient and attached.

Physician's Signature: Date Ordered:

Referring Physician: NPI:

DATE COLLECTED

Form for date collection with AM/PM options

Send Duplicate Report to:
Name:
Address:
City/State/Zip:

DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

Table with 3 columns for diagnosis codes

HEMATOPATHOLOGY REQUISITION

SPECIMEN / CLINICAL INFORMATION

COPY OF CBC AND PATIENT HISTORY SHOULD BE PROVIDED

Clinical History / Diagnosis (Please attach recent summary of patient history or notes from recent clinic visit)

Indicate type of specimen and # of tubes below

Blood Green Top(s): Purple Top(s): Smears: Bone Marrow Green Top(s): Purple Top(s): Core Biopsy: Clot: Smears: Touch Preps: Other:

ProPath Comprehensive Evaluation

Includes blood/bone marrow morphology, flow cytometry, cytogenetics, FISH, molecular diagnostics, and special and immunohistochemical stains as the ProPath hematopathologist deems medically necessary for a comprehensive diagnosis. PLEASE MAKE SURE ALL THREE ANTICOAGULANT TUBES CONTAIN SUFFICIENT (2-3 ml/tube) MARROW ASPIRATE.

INDIVIDUAL TESTS

Morphology

- Bone Marrow Morphology
Hematopathology Consultation for second opinion

Flow Cytometry

- Comprehensive Leukemia/Lymphoma
PNH, with FLAER

Molecular Diagnostics

- JAK2 V617F
JAK2 V617F reflex to JAK2 Exon 12
JAK2 V617F reflex to JAK2 Exon 12, MPL and CALR
JAK2 Exon 12
MPL W515L/K Mutation Detection
CALR
FLT3
NPM1
KIT D816 (Mastocytosis)
c-KIT (AML)
CEBPA
MYD88
T-Cell Clonality Assessment by TCR-Gamma PCR
B-cell Clonality Assessment by IgH PCR
IgVH Immunoglobulin Heavy-chain Variable-region (CLL)
IDH 1/2
BCR/ABL1 t(9;22) Quantitative Assay for CML

Cytogenetics/FISH

- Cytogenetics, Karyotyping
Cytogenetics with reflex FISH as necessary (indicate probes below)
FISH (Indicate probes below)

For single probe(s), check the individual probe boxes. For all probes in a panel, check the panel box.

MDS/AML Panel

- Deletion 5q/Monosomy 5
Deletion 7q/Monosomy 7
t(8;21), trisomy 8 - RUNX1T1/RUNX1
KMT2A (MLL) Rearrangement - 11q23
t(15;17) - PML/RARalpha
inv(16) - CBFbeta
17p13.1 - TP53
Deletion 20q

Eosinophilia Panel

- FIP1L1/CHIC2/PDGFRFA, Deletion 4q12
PDGFRB Rearrangement - 5q33
FGFR1 Rearrangement - 8q21
JAK2 - 9p24.1
BCR/ABL1

Chronic Myeloid Leukemia

- BCR/ABL1 rearrangement - t(9;22)

Large B-Cell Lymphoma Panel

- BCL6 Rearrangements - 3q27
MYC Rearrangements - 8q24
MYC/IgH t(8;14)
BCL2 Rearrangements - 18q21
Reflex to IGH/BCL2 - t(14;18)

CLL Panel

- Deletion 6q - MYB
Deletion 11q22.3 - ATM
Trisomy 12
Deletion 13q/Monosomy 13
IGH rearrangement - 14q32; reflex to CCND1/IGH, IGH/BCL2
19q13.2 rearrangements - BCL3
17p13.1 - TP53

Myeloma Panel

- Deletion 1p/1q Gain
Trisomy 5, 9, 15
Deletion 13q/Monosomy 13
IGH rearrangement - 14q32; reflex to FGFR1/IGH, CCND1/IGH
If 1st reflex neg, reflex to IGH/MAF, CCND3/IGH, IGH/MAFB
17p13.1 - TP53

ALL Panel

- Trisomy 4, 10, 17
BCR/ABL1 rearrangement - t(9;22)
KMT2A (MLL) rearrangement - 11q23
ETV6/RUNX1 (TEL/AML1) - t(12;21)
GH rearrangement - 14q32

Additional FISH Probes

- ALK - t(2;5) and variants
CDKN2A (p16) - 9p21
CCND1/IGH
FGFR3/IGH
MECOM - 3q26
BIRC3 (API)/MALT1 - t(11;18)
X/Y for Bone Marrow Transplant
IGH/BCL2



SPECIMEN REQUIREMENTS - TO SEND A SPECIMEN CALL 800.258.1253 or 214.638.2000

ADDITIONAL NOTES		TEST/ TECHNOLOGY	PERIPHERAL BLOOD	PERIPHERAL BLOOD SMEAR	BONE MARROW ASPIRATE	BONE MARROW SMEAR	BONE MARROW TREPHTHINE IMPRINT	BONE MARROW FIXED CLOT	BONE MARROW FIXED CORE	BONE MARROW FRESH CORE	LYMPH NODES / FRESH TISSUE
<p>Specimens should be sent as soon as possible after draw and kept at room temperature. Always include CBC and clinical history. Clearly label each tube with patient name and SS# or birth date. Clearly label each slide with the patient name and date in pencil. Allow slides to air-dry completely before placing in slide holder(s) provided.</p>		Blood Morphology 1		2 bedside blood smears (Air Dried Only)							
		Bone Marrow Morphology 1		2 bedside blood smears (Air Dried Only)	6 bedside marrow smears (Air Dried Only)	2 air dried imprint preparations from fresh bone marrow core biopsy specimen	In Formalin 4	Optimal length: 2.0 cm in Formalin 4			
<p>SPECIMEN STORAGE Store at room temperature. DO NOT freeze specimens.</p>		Blood or Marrow Flow Cytometry 2,3	7-10 ml in green top (sodium heparin) tube		2-3 ml in green top (sodium heparin) tube					Call ProPath	Call ProPath
		Blood or Marrow Cytogenetics/ FISH 2,3	7-10 ml in green top (sodium heparin) tube		2-3 ml in green top (sodium heparin) tube						Call ProPath
<p>SPECIMEN SHIPPING Ship at room temperature in Call ProPath Call ProPath special mailer. Please provide only one patient per mailer. DO NOT INCLUDE PATIENT IDENTIFYING INFORMATION ON THE MAILER. HIPAA regulations prohibit disclosure of confidential patient information.</p>		Blood or Marrow Molecular Diagnostics 2,3	2-3 ml in purple top (EDTA) tube		2-3 ml in purple top (EDTA) tube						Call ProPath
		<p>1. Smears should be made from non-anticoagulated blood or marrow. FRESH (<1 hour) EDTA (purple top) specimens may be used. SMEARS SHOULD NEVER BE MADE FROM HEPARINIZED SPECIMENS AS HEPARIN ADVERSELY AFFECTS MORPHOLOGY. 2. May use fresh core in case of "dry tap" (NO ASPIRATE). 3. May be performed on blood specimen IF blood involved by leukemic cells. Pathologist at ProPath can make this determination. 4. Place Formalin bottles with samples in SEALED plastic baggy (included) before putting in the special mailer.</p>									
<p>Complete Test Requisition Form. Include patient insurance information and appropriate clinical data. Retain the bottom copy for your records. To send specimen, call ProPath at 800.258.1253 or 214.638.2000 for pick-up.</p>											
<p>ProPath, 1355 River Bend Drive, Dallas, TX 75247 Client Services: Ph: 800.258.1253 or 214.638.2000, Fax: 214.237.1731 www.propath.com</p>											
FLUORESCENCE IN SITU HYBRIDIZATION (FISH) TESTS											
Acute Myeloid Leukemia (AML) / Myelodysplastic Syndromes (MDS) FISH Panel											
Detects deletions and other aberrations of chromosomes 5, 7 and 11 (MLL), gain of chromosome 8, deletions in the long arm of 20 and TP53 gene, inv(16) and the t(8;21) and t(15;17) rearrangements.											
Chronic Lymphocytic Leukemia / Small Lymphocytic Lymphoma (CLL) FISH Panel											
Detects deletions of MYB gene (chromosome 6), ATM gene (chromosome 11), long arm of chromosome 13 and TP53 gene, gain of chromosome 12 and the t(11;14) and t(14;18) rearrangements.											
Multiple Myeloma (MM) FISH Panel											
Detects gains of chromosomes 5, 9 and 15, deletions of the long arm of chromosome 13 and TP53 gene and the t(11;14) rearrangement.											

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D. Laboratory Tests	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any question that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

OPTION 3. I don't want the **D.** _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

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