

**MOLECULAR DIAGNOSTIC LABORATORY**  
**Barnes-Jewish Hospital, Institute of Health**  
 425 South Euclid Avenue  
 Room 5970, Mailstop #90-28-344  
 St. Louis, MO 63110



**Request For DNA Studies**  
**ONCOLOGY**

(314) 454-8685, 314-454-7601; FAX (314) 454-7616

URL: <http://pathology.wustl.edu/patientcare/molldiagnostic.php>

**COLLECTION INFORMATION:**  AM  PM  
 DATE \_\_\_\_\_ TIME \_\_\_\_\_ INITIALS \_\_\_\_\_

**ACCOUNT INFORMATION**

NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 PHONE \_\_\_\_\_  
 FAX \_\_\_\_\_

**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

ORDERING PHYSICIAN \_\_\_\_\_

**BILLING INFORMATION** } **BILL TO:**  ACCOUNT  PATIENT  INSURANCE  RESEARCH ACCT.  
 Medicare  Medicaid  CARE PARTNERS  PARTNERS HMO  
 ID # \_\_\_\_\_ ALPHA Code \_\_\_\_\_  GHP  OTHER \_\_\_\_\_

SECOND REPORT TO \_\_\_\_\_

ACCOUNT	PATIENT ACCT.	RESEARCH ACCT.
INSURED NAME (IF NOT PATIENT)		PLAN NAME
PATIENT ID	NO. SPEC RECEIVED	
REGISTERED BY	VERIFIED BY	

INSURANCE CO. \_\_\_\_\_ I.D. # \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ GRP. # \_\_\_\_\_  
 INSURED NAME (IF NOT PATIENT) \_\_\_\_\_ PLAN NAME \_\_\_\_\_  
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**Laboratory Use Only:**

Specimen Condition: \_\_\_\_\_  
 Specimen Number: \_\_\_\_\_  
 Date Received: \_\_\_\_\_  
 Time Received: \_\_\_\_\_

<input type="checkbox"/> Patient <input type="checkbox"/> Donor for: _____ <input type="checkbox"/> Pre-BMT <input type="checkbox"/> Post-BMT <input type="checkbox"/> Allogenic <input type="checkbox"/> Autologous	<input type="checkbox"/> BCR/ABL Quant. <input type="checkbox"/> IGH Hypermutation (IGHV) <input type="checkbox"/> IGH Rearrangement (B cell Clonality) <input type="checkbox"/> JAK2 Quant. <input type="checkbox"/> NPM1 <input type="checkbox"/> PML-RAR $\alpha$ (t(15;17)) Qualitative <input type="checkbox"/> STR Comprehensive testing (Patient Pre-BMT) <input type="checkbox"/> STR Identity testing <input type="checkbox"/> STR Donor testing (Donor Pre-BMT) <input type="checkbox"/> STR Separated PB Cells (Enrichment), 3mL per cell type <input type="checkbox"/> CD3 <input type="checkbox"/> CD19 <input type="checkbox"/> CD15 <input type="checkbox"/> CD56	<input type="checkbox"/> TCR Gamma Rearrangement <input type="checkbox"/> UGT1A1 <input type="checkbox"/> AML Diagnostic/Risk Stratification Panel (PML/RARA, FLT3, NPM1, DNMT3A, IDH1, IDH2, KIT, CEBPA per algorithm) <input type="checkbox"/> MPN Diagnostic/Risk Stratification Panel (BCR/ABL, JAK2, CALR, CSF3R) <input type="checkbox"/> Other (Prior Lab approval req'd)
<b>Sample Type:</b> <input type="checkbox"/> BM <input type="checkbox"/> PB Whole <input type="checkbox"/> PB T Lymphocytes <input type="checkbox"/> PB Myeloid cells <input type="checkbox"/> Lymph node <input type="checkbox"/> Other: _____	<b>Tube Type:</b> <input type="checkbox"/> Sodium EDTA <input type="checkbox"/> ACD <input type="checkbox"/> Paraffin Embedded <input type="checkbox"/> Frozen <input type="checkbox"/> Other: _____	

**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

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