LAB NO: _____ For TCCC Use Only **PHYSICIAN SIGNATURE: ATTENDING** **DIAGNOSIS OR SIGN /SYMPTOM (Required)** I.C.D. CODE: _____ COLLECTION DATE COLLECTION TIME COLLECTED BY	Specimen Information ☐ Bone Marrow ☐ Blood (NEOPLASTIC) (>5% circulating blasts) ☐ Blood (s/p BMT) ☐ Blood (NON-NEOPLASTIC) ☐ Lymph Node ☐ Solid Tumor SITE: _____ TYPE , IF KNOWN (SEE BELOW) ☐ Other Tissue/Fluid TYPE / SITE: ___	**CLINIC NAME / PHONE NO. (Required)** Physician Name: Office Address: Office Phone: Office Fax:

TENTATIVE DIAGNOSIS:		
√ HEMATOLOGICAL DISORDERS * PLEASE SPECIFY	√ SOLID TUMOR *SPECIFY TYPE OR FROZEN SECTION DIAGNOSIS	
☐ CML	☐ Desmoplastic Small Round Cell Tumor (DSCRT)	☐ Neuroblastoma
☐ AML, Type _____	☐ Ewing sarcoma / PNET	☐ Osteosarcoma
☐ ALL	☐ Fibrosarcoma / Mesoblastic Nephroma	☐ Renal cell carcinoma
☐ Myeloproliferative disorder	☐ Germ cell tumor	☐ Retinoblastoma
☐ Myelodysplastic disorder	☐ Glial tumor, grade:	☐ Rhabdomyosarcoma
☐ Cytopenia(s)	☐ Hepatoblastoma / HCC	☐ Synovial sarcoma
☐ *Other:	☐ Lipoblastoma / Liposarcoma	☐ Wilms tumor
☐ *Lymphoma	☐ Medulloblastoma	☐ Other:

DISEASE STATUS - Select all that apply		BONE MARROW / STEM CELL TRANSPLANT PATIENTS
☐ Suspected New Leukemia ☐ Perform ALL / AML FISH Panel	☐ Follow up (post-therapy) evaluation ☐ Remission ☐ Relapse	☐PRE ☐ POST BMT / SCT
☐ COG Study: #_____	☐ Known Down syndrome	DONOR SEX ☐ MALE ☐FEMALE
☐ Primary Solid Tumor	☐ Metastatic tumor / Recurrence	

√	TEST(S) REQUESTED: *IF REQUESTING CYTOGENETICS/FISH AND FLOW CYTOMETRY, PLEASE SUBMIT SEPARATE REQUESTS*		
	(√) Conventional Cytogenetics (G-banded Karyotype)		
	(√) FISH (Fluorescent *in situ* Hybridization) – Specify FISH test(s):		
	Flow Cytometry/ Immunophenotype (√ Please Specify)		Full Panel Leukemia / Lymphoma
			T & B Subsetting
			HLA B27

Additional comments: _____

_____

_____

Texas Children's Hospital -
Cytogenetic Laboratory
1102 Bates St., Feigin Center 11th Fl, Ste 1130
Houston, TX 77030
Cytogenetic Lab Ph 832-824-4457
Flow Cytometry Ph 832-824-4731
Fax 832-825-0111
Pneumatic tube: # 511

Weekend/Holiday Address:
Texas Children's Hospital -
Feigin Center
Cytogenetics (C/O Central Distribution)
6621 Fannin St. West Tower B1 Level
Ste B115.14
Houston, Texas 77030
Ph: 832-824-4457

TEXAS CHILDREN'S CANCER CENTER LABORATORY TEST REQUISITION

MRN:
NAME:
ACCT:
DOB:
SEX:

CYTOGENETIC AND FLOW CYTOMETRY TESTING

Texas Children's Hospital

Updated 11-08-12