

**NATIONWIDE CHILDREN'S***When your child needs a hospital, everything matters.™***Laboratory Client Services**

Tel: (614) 722-5477 / (800) 934-6575

NationwideChildrens.org/Lab**Oncology Genetic Test Requisition Form****Institute for Genomic Medicine (IGM) Clinical Laboratory**

Tel: (614) 722-5321 / Fax: (614) 722-5471

Ship Samples to: Nationwide Children's Laboratory Services

700 Children's Drive, Room C1955

Columbus, OH 43205 U.S.A.

PATIENT INFORMATION (Please Print or Place ID Label)					
Last Name		First Name		MI	
Date of Birth (DOB)	Sex Assigned at Birth Male Female Unknown	Gender Identity	SSN	Patient ID #/ MRN	
Street Address		City	State	Zip	
ORDERING PHYSICIAN INFORMATION (Please Print)					
Ordering Physician Name (REQUIRED)		Phone (REQUIRED)	Fax (REQUIRED)	NPI #	
Attending Physician Information - REQUIRED if Ordering Physician is a Trainee (e.g. Resident, Fellow)					
Attending Physician Name		Phone	Fax	NPI#	
Institution / Practice / Facility Name					
Street Address		City	State	Zip/Postal Code	
Physician Email (REQUIRED if sending from outside U.S.A.)			Country (if not U.S.A.)		
Ordering Physician Signature X			Date		
ADDITIONAL REPORT TO SENDOUT LABORATORY (Please Print):					
Name		Phone	Fax		
ICD-10 / CLINICAL DIAGNOSIS /SPECIAL INSTRUCTIONS					
ICD-10 Codes (REQUIRED)		Clinical Diagnosis (REQUIRED)			Age of Onset
Special Instructions / Notes			Has the patient had a bone marrow transplant? (REQUIRED) No Yes - Autologous (self) Yes - Allogeneic (donor)		
SAMPLE INFORMATION (Please List All Samples Being Submitted with This Form)					
Please check sample requirements and exclusions for each test on website Nationwidechildrens.org/Lab . Each submitted sample must be labeled with the name and at least one secondary identifier (e.g. MRN, DOB, SPID). Insufficiently labeled samples will require a signed specimen identification waiver and may result in delayed processing and/or reporting. Submitted samples will be consumed as needed to complete the requested testing which may result in depletion of submitted samples.					
<ul style="list-style-type: none">Bone marrow and Blood samples: Collect 4 mL of bone marrow or involved blood sample into EDTA tube. Ship overnight at room temperature. Samples must arrive in the laboratory within 48 hours from collection.Tissue samples: Tissue scrolls must be accompanied by H&E slide. Any H&E slide submitted with tumor sample must be from a consecutive cut from the submitted tumor section. Fresh tissue sample must arrive the laboratory within 48 hours from collection.				New York State Collected Specimens: <input type="checkbox"/> Please select this box and include the New York State Required Healthcare Provider Statement if NY state approved test (see website).	
Tumor / Involved Sample: Sample contains _____ % tumor nuclei / blasts <input type="checkbox"/> Bone marrow <input type="checkbox"/> Involved peripheral blood <input type="checkbox"/> Fresh tissue <input type="checkbox"/> Snap-frozen tissue <input type="checkbox"/> OCT-embedded tissue <input type="checkbox"/> FFPE tissue block <input type="checkbox"/> FFPE tissue scrolls <u>and</u> consecutively cut H&E slide <input type="checkbox"/> Other _____ <input type="checkbox"/> FFPE unstained slides and consecutively cut H&E slide			Collection Date Time	Sample Time Point: <input type="checkbox"/> Diagnosis <input type="checkbox"/> Relapse <input type="checkbox"/> Post-Treatment Day _____	
Normal Sample: Normal sample must contain 0% tumor nuclei / blasts <input type="checkbox"/> Bone marrow <input type="checkbox"/> Peripheral blood <input type="checkbox"/> Fresh tissue <input type="checkbox"/> Snap-frozen tissue <input type="checkbox"/> OCT-embedded tissue <input type="checkbox"/> FFPE tissue block <input type="checkbox"/> FFPE tissue scrolls <u>and</u> consecutively cut H&E slide <input type="checkbox"/> Uninvolved peripheral blood <input type="checkbox"/> Other _____			Collection Date Time	Sample Time Point: <input type="checkbox"/> Diagnosis <input type="checkbox"/> Relapse <input type="checkbox"/> Post-Treatment Day _____	
REQUIRED: A copy of the Pathology Report is required for each submitted tumor sample – if the report is not finalized, include a preliminary report with the sample submission and then fax the finalized report to 614-722-5471, once available. Failure to provide a finalized pathology report can result in a delayed test processing and/or result reporting.					



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Last, First _____

DOB or MRN _____

BILLING INFORMATION

***Insurance Bill ONLY available if patient was NOT an inpatient at time of collection**

- Insurance bill option is available for patients/insurance plans within the state of Ohio. For insurance bill, please attach the front and back copy of the patient's insurance card and complete the "Insurance Bill" section below
- For out-of-Ohio patients/insurance plans, institutional bill option is preferred. We **DO NOT** have contracts with most insurance plans outside of Ohio
- For **INTERNATIONAL** samples referred from outside the U.S.A. or Canada, we only accept institutional bill. Pre-payment or agreement of payment must be made **PRIOR TO** sending the sample. Payment can be made by wire transfer or by credit card. To arrange payment, please email LaboratoryBilling@NationwideChildrens.org
- We **DO NOT** offer Self-pay option at this time
- Please contact Laboratory Client Services for more information at 1-800-934-6575
- **Please select ONE Billing method below. Billing selection must be completed to proceed with testing**

■ INSTITUTIONAL/CLIENT BILL (Please Print)

Billing Contact Name:

Phone

Fax

Email Address (**Required**)

Institution / Hospital / Laboratory Name

Client Account Number

(Please contact laboratorybilling@nationwidechildrens.org if you are unsure of your account number)

Street Address

City

State / Province

Zip Code

Country

☐ **Send a result copy to sending institution via:**

☐ Above Fax number ☐ Above Email address

☐ Other Fax/Email _____

Other Information:

■ INSURANCE/PATIENT BILL (Please Print)

Please Attach a Front and Back Copy of Insurance Card

Legal Guardian Last Name:

Legal Guardian First Name, MI

Legal Guardian DOB

Legal Guardian SSN

Relationship to Patient

☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Subscriber Last Name

Subscriber First Name, MI

Subscriber DOB

Subscriber SSN

Policy #

Group #

Insurance Company Name

Insurance Address

City

State

Zip

Secondary Insurance Company Name

PATIENT CONSENT FOR INSURANCE BILL

I will fully abide with Nationwide Children's Hospital Laboratory Services by providing all necessary documents needed for insurance billing and appeals. I understand that I am responsible for the payment of this test whether through my insurance company or myself.

Patient Signature: X _____



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*Internal pathology review by Nationwide Children's pathologist may be performed on submitted samples to assess for tumor/blast content.

HEMATOLOGIC CANCER

☐ Hematologic Cancer Fusion Analysis by NGS [test code: HEMFUSN]

Identifies gene fusions for 148 genes (see website for list of all gene partners).

***At least 10% blasts** must be present in the **Fresh, Snap-frozen, or OCT** samples.

***At least 25% blasts/tumor** must be present in the **FFPE tissue block, scrolls, or unstained slides** (based on internal pathology review). Sample acquisition **PRIOR TO** receiving treatment is strongly preferred.

SOLID TUMOR

☐ Solid Tumor Fusion Analysis by NGS [test code: TUMFUSN]

Identifies gene fusions for 151 genes (see website for list of all gene partners).

***At least 10% tumor** must be present in the submitted **Fresh, Snap-frozen, OCT, or Bone marrow** samples.

***At least 25% tumor** must be present in the submitted **FFPE tissue block, scrolls, or unstained slides** (based on internal pathology review). Sample acquisition **PRIOR TO** receiving treatment is strongly preferred.

CNS / BRAIN TUMOR

☐ CNS Tumor Classification by Methylation Array [test code: CTCMA]

***At least 60% tumor** must be present in the submitted sample (based on internal pathology review).

Snap-frozen tissue is Preferred

MEDULLOBLASTOMA

☐ MYCN (N-MYC) and MYC (C-MYC) Amplification by FISH [test code: FISHMB]

***At least 10% tumor (30% if bone marrow)** must be present in the submitted sample (based on internal pathology review).

FFPE unstained slides are Preferred; please submit 6 slides (3 micron thick) **AND** consecutively cut H&E slide.

ALVEOLAR RHABDOMYOSARCOMA

☐ FOXO1 (FKHR) Rearrangement Detection by FISH [test code: FISHFKHR]

Identifies PAX3-FOXO1 and PAX7-FOXO1 fusions [t(2;13)(q35;q14) and t(1;13)(p36;q14)]

If FOXO1 rearrangement is identified, reflex to PAX3 will occur first. If that is negative, reflex to PAX7 will then occur.

***At least 10% tumor** must be present in submitted sample (based on internal pathology review).

FFPE unstained slides are Preferred; please submit 6 slides (3 micron thick) **AND** consecutively cut H&E slide

SARCOMA

Soft Tissue Sarcoma Tumor Analysis by RT-PCR [test code: RTPCR]

Snap-frozen tumor tissue is Preferred

**FFPE Sample is NOT
ACCEPTED for This Test**

☐ Full Panel (includes all listed below)

or Specific RT-PCR for the following selected sarcoma types:

- ☐ **Ewing sarcoma** EWSR1::FLI1 and EWSR1::ERG fusions [t(11;22)(q24;q12) and t(21;22)(q22;q12)]
- ☐ **Alveolar rhabdomyosarcoma** PAX3::FOXO1 and PAX7::FOXO1 fusions [t(2;13)(q36;q14) and t(1;13)(p36;q14)]
- ☐ **Synovial sarcoma** SS18::SSX1 and SS18::SSX2 fusion [t(X;18)(p11.2;q11.2)]
- ☐ **Desmoplastic small round cell tumor** EWSR1::WT1 fusion [t(11;22)(p13;q12)]
- ☐ **Infantile fibrosarcoma/Congenital mesoblastic nephroma (CMN)** ETV6::NTRK3 fusion [t(12;15)(p13;q25)]

☐ EWSR1 FISH Tumor Analysis (test code: FISHEWSR1)

Identifies if EWSR1 gene is rearranged but **will not identify the EWSR1 gene fusion partner**.

***At least 10% tumor** must be present in submitted sample (based on internal pathology review).

FFPE unstained slides are Preferred; please submit 6 slides (3 micron thick) **AND** consecutively cut H&E slide

SOMATIC DISEASE/GERMLINE COMPARATOR EXOME

☐ Somatic Disease/Germline Comparator Exome [test code: SDGC]

A disease-involved sample **AND** an unaffected comparator sample are **REQUIRED**.

***For malignant disease, at least 20% tumor content/blasts** must be present in the submitted affected sample for single-nucleotide and small insertion-deletion variant resolution and reporting (based on pathology review).

***For malignant disease, at least 60% tumor content/blasts** must be present in the submitted affected sample for sensitive resolution of copy number variation (CNV) and loss of heterozygosity (LOH) to enable interpretation (based on pathology review). Sensitivity in calling CNV and LOH will be limited, and at times, assay resolution of these events will preclude interpretation and reporting of CNV and LOH, if the submitted specimen contains less than 60% disease-content

Checklist of Required Items: ☐ Disease-involved sample ☐ Unaffected sample



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NEUROBLASTOMA

☐ **ALK Amplification by FISH** [test code: FISHALK]

**At least 10% tumor (30% if bone marrow) must be present in the submitted sample (based on internal pathology review).
FFPE unstained slides are Preferred; please submit 6 slides (3 micron thick) **AND** consecutively cut H&E slide*

☐ **MYCN (N-MYC) Amplification by FISH** [test code: FISHTUMOR]

**At least 10% tumor (30% if bone marrow) must be present in the submitted sample (based on internal pathology review).
FFPE unstained slides are Preferred; please submit 6 slides (3 micron thick) **AND** consecutively cut H&E slide*

☐ **DNA Ploidy Analysis** [test code: DNAP]

Slides are **NOT** accepted for this test

ONCOLOGY CHROMOSOMAL MICROARRAY ANALYSIS

☐ **Oncology Chromosomal Microarray Analysis** [test code: TONCMA] — Identifies LOH and Copy Number Abnormalities

At least 40% tumor in solid tumor samples **OR at least 20% blasts for hematologic malignancies must be present in the submitted sample (an internal pathology review may be performed on submitted samples to verify tumor/blast content.)*

****Specify the indication:** ☐ Neuroblastoma ☐ B-cell acute lymphoblastic leukemia (B-ALL)

☐ Wilms tumor ☐ Other: _____

CUSTOM CONFIRMATION TESTS

TARGETED TUMOR VARIANT ANALYSIS - Confirmatory Test for a Known Somatic Variant

☐ **Targeted Tumor Variant Analysis** [test code: TTVA]

A copy of the previous research/clinical tumor sequencing result is **REQUIRED**.

**At least 50% blasts must be present in hematologic cancer samples, and*

**At least 40% tumor must be present in solid tumor samples (based on internal pathology review).*

Submission of a normal sample (containing 0% tumor) is recommended but not required.

Genome Build: ☐ GRCh37 (hg19) ☐ GRCh38

1. Gene: _____ Variant (c./p.): _____ Transcript (NM#): _____

2. Gene: _____ Variant (c./p.): _____ Transcript (NM#): _____

3. Gene: _____ Variant (c./p.): _____ Transcript (NM#): _____

Previous sequencing performed at (Lab Name): _____

Previous tumor sequencing performed as a ☐ Clinical testing ☐ Research testing

TARGETED TUMOR FUSION ANALYSIS - Confirmatory Test for a Known Gene Fusion

☐ **RT-PCR Fusion Confirmation** [test code: FUSNCON]

A copy of the previous research/clinical tumor fusion result is **REQUIRED**.

**At least 10% tumor must be present in the submitted hematologic or solid tumor sample (based on internal pathology review)*

**This Test is NOT for
MRD Detection**

Genome Build: ☐ GRCh37 (hg19) ☐ GRCh38

Test for a fusion between these 2 genes:

• 5' Fusion Gene Partner: _____ Transcript (NM#): _____

Breakpoint: Exon: _____ Genomic Coordinate: _____

• 3' Fusion Gene Partner: _____ Transcript (NM#): _____

Breakpoint: Exon: _____ Genomic Coordinate: _____

Test for additional gene fusions (specify): _____

Previous fusion analysis performed at (Lab Name): _____

Previous tumor fusion analysis performed as a: ☐ Clinical testing ☐ Research testing



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Ship Samples and Completed Test Requisition Form to:

Nationwide Children's Hospital Laboratory

700 Children's Drive, Room C1955

Columbus, OH 43205 U.S.A.

- Ship samples via Overnight Courier. Samples must arrive the laboratory within 48 hours. Saturday deliveries accepted. Please check "Saturday Delivery" on shipment label.
- For questions regarding testing, specimen requirements or transport, please call IGM Clinical Laboratory at (614) 722-5321 or Lab Client Services at (800) 934-6575.

Sample Return Request:

Tissue blocks will be returned after testing is complete if there is remaining sample. Provide return details below:

Ship Back to: **Name:** _____ **Phone:** _____

Address: _____
