

**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

**Laboratory Client Services** Tel: (614) 722-5477 / (800) 934-6575 NationwideChildrens.org/Lab

- Tradion Wide Or	mar ensier g	Lab			C	olumb	us, OH 4	3205	U.S.A.
PATIENT INFORM Last Name	ATION (F	Please Print or		D Label) First Name					MI
Date of Birth (DOB)	Sex Assigned Male Fe	d at Birth Ge male Unknown	ender Ider	itity	SSN			Patient	ID #/ MRN
Street Address	•	•	(	City	· ·	Sta	ate		Zip
<b>ORDERING PHYSI</b>	CIAN INF	ORMATION	(Please	Print)					
Ordering Physician Name			<u>`</u>	(REQUIRED	) F	Fax (R	EQUIRED	)	NPI #
Attending Physician Info Attending Physician Name		QUIRED if Orderii	n <b>g Physic</b> Phone	cian is a Tra		<b>g. Resi</b> Fax	dent, Fel	low)	NPI#
Institution / Practice / Faci	lity Name		1		<u> </u>				
Street Address				City		Sta	ate		Zip/Postal Code
Physician Email (REQUIR	ED if sending	g from outside U.S	S.A.)			Co	ountry (if r	not U.S	A.)
Ordering Physican Signa	ture					Da	ite		
	ODT TO	DENIDOUT LA		TODY (F	N I	Duin4\			
ADDITIONAL REP	ORTIOS	SENDOUT LA			Please I				
Name				Phone		Fa	X		
ICD-10 / CLINICAL	DIAGNO	SIS /SPECIAL	INST	RUCTION	IS				
ICD-10 Codes (REQUIRE		Clinical Diagnosi							Age of Onset
Special Instructions / No	tes			Has			l a bone n utologous (		ransplant? (REQUIRED) Yes - Allogeneic (donor)
SAMPLE INFORMA	ATION (PI	lease List All S	amples	Being Si	ubmitte	ed wit	h This	Form)	
Please check sample red	•								
Each submitted sample mus									<u>ao</u> .
Insufficiently labeled sample						_			g and/or reporting.
Submitted samples will be o	•				-				
Bone marrow and Blood									rk State Collected Specimens:
Ship overnight at room to	emperature. Sa	amples must arrive i	n the labo	ratory within	1 48 hours	s from o	collection.	-	se select this box and include
• Tissue samples: Tissue sci								_	v York State Required
must be from a consecut			r section. I	Fresh tissue s	ample mi	ust arri	ve the		are Provider Statement if e approved test (see website).
laboratory within 48 hou	irs from collec	tion.							
Tumor / Involved Sam					ts	(	Collection	n Date	Sample Time Point:
☐ Bone marrow		d peripheral blood		resh tissue					☐ Diagnosis
<ul><li>☐ Snap-frozen tissue</li><li>☐ FFPE tissue scrolls <u>ar</u></li></ul>		bedded tissue		FPE tissue b ther	DIOCK		Time		<ul><li>☐ Relapse</li><li>☐ Post-Treatment</li></ul>
☐ FFPE ustained slide				uiei					Day
Normal Sample: Norm	nal sample m	nust contain 0% tu	mor nucl	ei / blasts		- 1	Collection	n Date	Sample Time Point:
☐ Bone marrow	☐ Peripher			resh tissue					□ Diagnosis
☐ Snap-frozen tissue		bedded tissue		FPE tissue b		, J.	Time		☐ Relapse
<ul><li>☐ FFPE tissue scrolls <u>ar</u></li><li>☐ Other</li></ul>	<u>na</u> consecuti	very cut H&E slide	⊔U	ninvolved p	eripneral	poola			□ Post-Treatment Day
RECUIRED: A conv of th	a Pathology	Report is required	d for each	h submitted	ltumors	sample	_ if the r	enort i	s 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.

SM-REQ-EXT-F-13.16; Last Updated August 2025



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Patient Name (or place patient ID label)			
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 <u>INTERNATIONAL</u> samples referred from outside the U.S.A. or Canada, we only accept institutional bill. Pre-payment or agreement of payment must be made <u>PRIOR TO</u> sending the sample. Payment can be made by wire transfer or by credit card. To arrange payment, please email <u>Laboratory Billing@NationwideChildrens.org</u>
- We **DO NOT** offer Self-pay option at this time

	aboratory Client Services for moves to the Billing method below. Billing			with testing			
	NAL/CLIENT BILL (Plea	ase Print)	URANCE/PATIE	ENT BILL (	(Please Print) by of Insurance Card		
Billing Contact Name	:	Legal Gu	ardian Last Name:				
Phone	Fax	Legal Gu	Legal Guardian First Name, MI				
Email Address ( <b>Required</b> )		Legal Gu	ardian DOB	Legal Gu	ardian SSN		
Institution / Hospital / Laboratory Name			Relationship to Patient  ☐ Self ☐ Spouse ☐ Parent ☐ Other				
	atorybilling@nationwidechildre		er Last Name				
are unsure of your account number)		Subscribe	Subscriber First Name, MI				
Street Address		Subscribe	Subscriber DOB				
City		Subscribe	er SSN				
State / Province		Policy #		Group #			
Zip Code		Insurance	e Company Name				
Country		Insurance	e Address				
□ Send a result copy to sending institution via: □ Above Fax number □ Above Email address □ Other Fax/Email		City	State		Zip		
		Seconda	Secondary Insurance Company Name				
Other Information:		I I					
PATIENT CONSI	ENT FOR INSURANCE B	ILL					
	Nationwide Children's Hospita I understand that I am respon						

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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.	
* <u>At least 25% tumor</u> must be present in the submitted <u>FFPE tissue block, scrolls, or unstained slides</u> (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 <b>Preferred</b>	
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 <b>Preferred</b> ; please submit 6 slides (3 micron thick) <u>AND</u> 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 <b>Preferred</b> ; please submit 6 slides (3 micron thick) <u>AND</u> consecutively cut H&E slide	
SARCOMA	
Soft Tissue Sarcoma Tumor Analysis by RT-PCR [test code: RTPCR]  Span-frozen tymor tissue is Professed.  FFPE Sample is NOT	
ACCEPTED for This Tost	
Tuli Fallel (lifelides all listed below)	
or Specific RT- PCR for the following selected sarcoma types:	
☐ Ewing sarcoma	
☐ 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/Congential 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.	
* <u>At least 10% tumor</u> must be present in submitted sample (based on internal pathology review).	
FFPE unstained slides are <b>Preferred</b> ; 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	
The state of the s	



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NEUROBLAS1					
* <u>At least 10%</u>		<u>v)</u> must be prese		d sample (based on internal pati <u>AND</u> consecutively cut H&E slic	
* <u>At least 10%</u>	(C) Amplification by F stumor (30% if bone marrow ed slides are Preferred; pleas	<u>v)</u> must be prese	ent in the submitted	d sample (based on internal path AND consecutively cut H&E slic	nology review). Je
	lastoma Panel [test cood tumor must be present in su		(based on internal	pathology review).	
□ DNA Ploidy A	Analysis [test code: DNAF	·]	Slides are <u>NOT</u> acc	cepted for this test	
ONCOLOGY CH	HROMOSOMAL MICR	OARRAY A	NALYSIS		
• • • • • • • • • • • • • • • • • • • •		•	_	<ul> <li>Identifies LOH and Copy Nur</li> </ul>	
submitted sar	mple (an internal pathology re	eview may be pe	erformed on subm	matologic malignancies must be itted samples to verify tumor/bla	ast content.)
**Specify th			<del>-</del>	mphoblastic leukemia (E	
	☐ Wilms	tumor 🗆	Other:		<del></del>
CUSTOM CON	FIRMATION TESTS				
TARGETED T	UMOR VARIANT AN	ALYSIS - Co	onfirmatory Te	st for a Known Somatic	Variant
☐ Targeted Turn A copy of the *At least 50% *At least 40%	mor Variant Analysis previous research/clinical tu blasts must be present in he tumor must be present in so f a normal sample (containing	[test code: TTV/ Imor sequencing Imatologic cance Indiction sample	A] g result is <b>REQUII</b> <u>e</u> r samples, and es (based on interi	RED. nal pathology review).	
	d: □ GRCh37 (hg19)	-	<u>oommonada</u> sarn	ot roquirou.	
	, ,			Transcript (NM#):	
				Transcript (NM#):	
	Variant (c./p.):				
Previous seq	uencing performed at (L	_ab Name): _			
Previous tum	or sequencing performe	ed as a □	Clinical testing	□ Research testing	
TARGETED T	UMOR FUSION ANAI	YSIS - Con	firmatory Test	for a Known Gene Fusi	on
A copy of the p * <u>At least 10% t</u>	ion Confirmation [test previous research/clinical tunk tumor must be present in the present in the properties of the present in the properties of the present in the properties of the present in the pre	nor fusion resuli submitted hema	t is <b>REQUIRED</b> .	This Test is <u>NOT</u> for MRD Detection	
Genome Build	I: □ GRCh37 (hg19)	☐ GRCh38			
Test for a fusi	on between these 2 gen	es:			
• 5' Fusion G	ene Partner:	Transcr	ipt (NM#):		<del></del>
Breakpo	oint: Exon: Gend	omic Coordina	ate:		
• 3' Fusion G	ene Partner:	Transcr	ipt (NM#):		
Test for additi	onal gene fusions (spec	;ify):			
				in December 4 actions	
rievious tum	or iusion anaivsis derto	imeu as a:	+ + Giriicai testi	ing   Research testing	



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Please check sample requirements and exclusions for each test on website Nationwidechildrens.org/Lab.

## **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 o	complete if there is remaining sample. Provide return details below:
Ship Back to: Name:	Phone:
Address:	