Northwell Health℠ Laboratories

Effective Date: 09/18/2023

Molecular Genetics Test Request Form

Laboratory Phone: 516-562-4179; Fax: 516-562-2691; Hours of Operation: M-F 6am to 6pm
NYS Civil Rights Law requires that the ordering physician obtain consent from the patient or legal guardian for Molecular Genetic study laboratory tests. Please have the patient sign the consent provided on the form or indicate that you discussed the genetic disease/s listed on this form that the patient will be tested for. (Specimen instructions on the other side)

PART I: PATIENT INFORMATION

Patient Name: _____

Med. Rec. No.: _____ Date of Birth: _____

Age: _____ Sex: _____

Physician: _____ Signature: _____

Physician Phone: _____Fax: _____

PART IIIA: MOLECULAR GENETIC STUDY REQUESTED

[ ] Factor-V Leiden
[ ] Prothrombin gene mutation
[ ] Hemochromatosis
[ ] MTHFR
[ ] Fragile-X
[ ] HIBM
[ ] SMA
[ ] HLA-B*57:01
[ ] HLA B27 Genotyping Test

PART IIIB: INFORMED CONSENT

(Mandated by the NYS Civil Rights Law Section 79-I for constitutional genetic analysis by chromosome study or by DNA study)
Consent: Forwarded / Retained in the office

I have received information regarding the disease(s) for which I am being tested and the necessity of the above test and hereby give my consent to perform the test(s). I may seek genetic counseling prior to this consent.
I also understand that a positive result may not result in disease, but increases the risk for the disease. Such a result may require genetic counseling and/or further testing and/or further physician consultation. A negative result does not rule-out increased risk for disease. The test may give false negative result due to changes not detectable by the method and/or reagents used. Any leftover material may be used as control material, or for research for teaching purpose anonymously (if suitable), or it will be discarded after 60 days from reporting results. Results of the test(s) are provided to my physician, and anyone else who is legally authorized.

_____ _____
Patient / Guardian signature Physician signature

_____ _____
PRINT NAME PRINT NAME

PART II: PATIENT CLINICAL INFORMATION/HISTORY

Indication for test: _____

Diagnosis: _____

Date and time of specimen collected: _____

Specimen: **BM Aspirate** **BM-Bx** **Blood**
Tissue Sections **Tumor Tissue**

PB-WBC count: _____ Blast count: _____

PART IV: MOLECULAR ONCOLOGY TEST REQUESTED

[ ] Immunoglobulin Gene Rearrangements (B-Cell)

[ ] T-Cell Gene Rearrangements

[ ] FLT3 ITD and TKD Mutation Analysis

[ ] CALR

[ ] Quantitative BCR::ABL1 t(9:22) for CML/ALL [ ]p210 [ ]p190

[ ] Quantitative JAK2 V617F mutation

[ ] DNA & HOLD- myeloid panel

[ ] MPL Mutations W515L, W515K, W515A and S505N

[ ] Other_____

FOR LAB USE ONLY

_____

_____

_____

_____

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Instructions for specimen collection, transportation and/or storage

Molecular Specimens	Tube Type	Handling and Storage Conditions
Peripheral Blood (at least 2ml)	Lavender Top (EDTA)	Room Temperature 20-25°C or refrigerate at 4°C / **DO NOT FREEZE**
Bone Marrow	Lavender Top (EDTA)	Room Temperature 20-25°C or refrigerate at 4°C / **DO NOT FREEZE**
Tissues	Cut 10 sections at 10 micron thick, place in a 1.5ml microfuge tube or on slides.	Room Temperature 20-25°C
BCR::ABL1– Peripheral blood/Bone Marrow – (at least 3 ml)	Lavender Top (EDTA)	**Refrigerate at 4°C, deliver to lab within 72 hours/ DO NOT FREEZE**
Pleural Fluid, submit at least 0.5 x10^7 cells	collected in sterile tube	Transport at 4°C
FNA, submit at least 0.5 x10^7 cells	collected in sterile tube	Transport at 4°C

Transportation: Submit all specimens to the laboratory ASAP after collection at room temperature. DO NOT EXPOSE THE SPECIMEN TO EXTREME TEMPERATURES (COLD OR HEAT) DURING TRANSPORTATION. DO NOT FREEZE THE SPECIMEN.

BCR::ABL1 must be refrigerated at 4°C and arrive within 72 hours of collection.

Any questions? Call the laboratory at 516-562-4179