The University of Vermont MEDICAL CENTER

Hemepath / Flow Cytometry / Genetic Laboratory Form

111 Colchester Avenue • Burlington, VT 05401 • (802) 847-5121
www.uvmhealth.org/medcenterlabs

Provider: _____
First and last name required
Dr. No: _____

BILLING PROVIDER

PATIENT DEMOGRAPHIC INFORMATION

PATIENT

NAME (LAST, FIRST, MI) PATIENT, MRN

FAHC - MRN | DOB | SEX ☐ M ☐ F

SOCIAL SECURITY NO.

ACCOUNT INFORMATION / REPORT CODE
HPMC-Porter Medical Center 802-388-4747

Additional copy of report to (first and last name required):

CLIENT I.D.

BILLING INFORMATION

☐ BILL INSURANCE
FILL IN LINES 1-5 OR SEND FACE SHEET

☐ BILL CLIENT ACCOUNT
FILL IN LINES 1-5 OR SEND FACE SHEET
☐ 9 960-0149

☐ NO INSURANCE BILL PATIENT
FILL IN LINES 1-2

BILLING INFORMATION AVAILABLE

1 RESPONSIBLE PARTY NAME | PHONE NO.

2 ADDRESS (STREET, TOWN, STATE, ZIP CODE)

3 MEDICARE NO.* | MEDICAID NO. | MANAGED CARE MEDICAID NO. | STATE

4 INSURANCE COMPANY NAME | CERT. NO. | GROUP NO.

5 SUBSCRIBER NAME | SUBSCRIBER'S DOB | RELATIONSHIP | EMPLOYER

*FOR MEDICARE PATIENTS: Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would be otherwise covered is not "reasonable and necessary" under Medicare payment standards, Medicare will deny payment for that service.

Preauthorization: For Molecular and Chromosome testing please obtain preauthorization from the patients insurance prior to sample collection.

DIAGNOSIS INFO

Signs, symptoms, pertinent clinical history and lab data required. ICD-10 codes must reflect the same information that appears in the patients medical record. No rule outs R/O.

SAMPLE INFO

Please Contact Customer Service prior to sending sample 800-991-2799 or 847-5121.

Collect Date / / | Collect Time :

SAMPLE TYPE (Check √)
- ☐ Blood
- ☐ Bone Marrow (BM)
- ☐ Lymph Node
- ☐ Tissue / Tumor
- ☐ POC

Other:

MEDIA (Check √)
- ☐ Na Heparin
- ☐ BM Media
- ☐ EDTA
- ☐ Formalin

Time in Formalin _____:_____

- ☐ RPMI
- ☐ Hanks Solution
- ☐ Other:

LAB USE: AGG-7

Other Testing:

MUST HAVE AT LEAST 2 PATIENT IDENTIFIERS ON EACH PATIENT SAMPLE

√ BONE MARROW MORPHOLOGIC EVALUATION (Check all that apply)

- ☐ Core biopsy (10% Zinc Formalin)
- ☐ Clot/Particle sections (10% Zinc Formalin)
- ☐ Peripheral Blood _____ Smears _____ EDTA

*Current CBC and Differential results are required for complete evaluation

√ BONE MARROW WITH REFLEX TESTING (Check all that apply)

- ☐ For a new diagnosis
- ☐ For a follow-up of a known diagnosis (indicate dx here) _____
- ☐ For possible new onset acute leukemia or pancytopenia (Collect extra EDTA Tube)
- ☐ For Evaluation of myeloma or MGUS (Collect extra Sodium Heparin Tube)
- ☐ This patient requires additional non-reflex testing (Indicate testing here) _____

BONE MARROW REFLEX OPTION: If you wish to decline reflex indicate here (Check all that apply)

- ☐ I decline Cytogenetics
- ☐ I decline Flow Cytometry
- ☐ I decline FISH
- ☐ I decline Mutational Analysis
- ☐ I decline Multigene Panel (genomic testing)

√ CYTOGENETICS

Chromosome Analysis
Bone Marrow collect BM Media or NaHep
Blood collect NaHep
Lymph Node collect in Hanks Solution
POC/Tissue/Tumor collect Hanks Solution

√ FLOW CYTOMETRY

Leukemia / Lymphoma Panel
Bone Marrow collect NaHep
Blood collect NaHep
Lymph Node/Tissue collect in RPMI Media

√ FISH CONGENITAL
Blood collect NaHep

- DiGeorge Syndrome 22q11.2
- Williams Syndrome 7q11.23

√ FISH NEOPLASTIC (BM Mediator NaHep)

- t(8;14) MYC/IGH and MYC Burkitt's Lymphoma
- t(8;21) RUNX1/RUNX1T1 Acute Myeloid Leukemia (AML)
- t(9;22) BCR/ABL Chronic Myelogenous Leukemia (CML)
- t(11;14) CCND1/IGH Mantle Cell Lymphoma
- 11q23 MLL Rearrangement AML, ALL, MDS
- t(12;21) ETV6/RUNX1 Acute Lymphoblastic Leukemia (ALL)
- t(14;18) BCL2/IGH Follicular Lymphoma
- t(15;17) PML/RARA Acute Promyelocytic Leukemia (APL)
- Inv (16) CBFB Rearrangement AML with Eosinophils
- CLL FISH Panel

INITIAL TEST	REFLEX CRITERIA	REFLEX TEST(S)	ADDITIONAL CPT BILLED
Bone marrow aspiration and/or biopsy	Suspicion of a hematolymphoid malignancy	Cytogenetics, flow cytometry, FISH, PCR, mutational analysis, and/or genomic testing	Examples include 88233, 88264, 88291, 88184-88189, and additional codes as may be applicable

Genetics Testing: Submission of an order for any Laboratory test constitutes the certification to UVMMC that (1) the Ordering Provider has obtained the "Informed Consent" of the patient as required by any applicable state or federal laws with respect to each test ordered; and (2) the Ordering Provider has obtained from the patient authorization permitting UVMMC to report results of each test ordered directly to the ordering physician.

SIGNATURE Please provide signature with lab orders | DATE | TIME

UVMMC LABORATORY COPY