MOLECULAR GENETICS TEST REQUEST FORM

University of North Carolina Hospitals
101 Manning Drive
Molecular Genetics Laboratory, Rm. 1046 Anderson Pav.
Chapel Hill, NC 27514
Phone: (984) 974-1825 Fax: (984) 974-2496
http://labs.unchealthcare.org/
MIM #963, Chart Location: Physician Orders

PATIENT INFORMATION

Full Name (Last, First, M.I.):
UNC Medical Record Number:
NOT a UNC Hospitals Patient? Add'l Information Needed for Registration
Date of Birth:
Patient Address:
City / State / Zip:
Telephone:

☐ **Bill Patient's Insurance (UNC Healthcare ONLY)** ☐ **Bill Facility**

Form Completed By: _____ **Date:** _____ **Facility Name:** _____
Phone Number: _____ **Facility Address:** _____
Fax Number: _____ **City / State / Zip:** _____

Indication for Testing and Supporting ICD-10 Code(s): _____

Ordering Physician (Print) _____ **Signature:** _____ **Date:** _____

SPECIMEN TYPE SUBMITTED:

☐ **Blood (ACD or EDTA tube)** ☐ **Bone Marrow**
☐ **Cerebrospinal Fluid (CSF)** ☐ **Other*:** _____
Date and Time of Collection: _____

***Extracted nucleic acid only accepted from CLIA-approved laboratories.**

PARAFFIN EMBEDDED TISSUE SUBMITTED:

Tissue Type: _____ **Case Number:** _____
Date of Collection: _____
Archived Specimen Located at:
☐ **UNC Hospitals Surgical Pathology Department**
☐ **Other Institution (Provide Facility Information Above)**

☐ **A1AT deficiency (*SERPINA1 Z and S*)**
☐ ***APOL* 1 Genotyping**
☐ **B-cell clonality (*IgH* and *IgK*)**
☐ **T-cell clonality (*TRG*)**
☐ **BCR/ABL1 p210** ☐ **BCR/ABL1 p190**
☐ **BCR/ABL1 mutations (*TKI resistance*)**
☐ **Connexin panel (includes *GJB2* and *GJB6*)**
☐ **CMV from Guthrie Card**
☐ **Cystic Fibrosis mutations**
☐ **Carrier Screen** ☐ **Diagnostic**
☐ **DNA fingerprinting (marrow engraftment/chimerism)**
☐ **With CD3 Fraction** ☐ **With CD33 Fraction**
☐ **Extract and Hold** ☐ **DNA** ☐ **RNA**
☐ **Factor V Leiden (*FV1691G>A*)**
☐ **Prothrombin (Factor II, 20210G>A)**
☐ ***FLT3* ITD Only**
☐ ***FLT3* TKD and ITD Mutation Panel**
☐ **Fragile X syndrome (*FMR1*)**
☐ **Kidney Genetic Mutation Panel *(Alport and FSGS)***
☐ **Hemochromatosis (*HFE C282Y and H63D*)**
☐ ***JAK2* V617F, Quantitative Mutation**
☐ **Myeloid Mutation Panel - Select Indication:**
☐ **AML (Includes *FLT3 ITD* and *FLT3 TKD*)**
☐ **MDS & MPN**
☐ **Myeloproliferative Neoplasm Hot Spot (*CALR, JAK2, MPL*)**
☐ ***BRAF* Somatic Mutation, Hematologic malignancies**
☐ ***TP53* Somatic Mutation, Hematologic malignancies**
☐ ***NPM1* Quantitative RNA PCR**
☐ **Clopidogrel (Plavix) response genotyping (*CYP2C19*)**
☐ **Prader Willi/Angelman syndromes**
☐ **Primary ciliary dyskinesia (PCD)**
☐ **SMA Testing** ☐ **Carrier Screen** ☐ **Diagnostic**
☐ ***UGT1A1* genotyping**
☐ **Other:** _____

☐ **MSI DNA Assay (Microsatellite Instability):** 10 unstained sections of tumor tissue 5-10 micron thickness (preferably greater than 70% tumor on the slide) plus 1 "H&E recut" of the same section ***AND*** 10 unstained sections of any non-tumor tissue plus 1 "H&E recut" of the same non-tumor tissue (22 slides total)

☐ **MSI DNA Assay with Immunohistochemistry (IHC) staining* (MLH1, MSH2, MSH6, PMS2):** 15 unstained sections of tumor tissue 5-10 micron thickness (greater than 50% tumor on the slide) plus 1 "H&E recut" of the same section ***AND*** 10 unstained sections of any non-tumor tissue plus 1 "H&E recut" of the same non-tumor tissue (27 slides total).

For the following test(s): 10 unstained sections of tumor tissue 4 – 5 micron thickness **and** 1 "H&E recut" of the same section. (11 total slides).
The following tests require greater than 50% tumor:

☐ ***IDH1& IDH2*** ☐ ***TERT*** ☐ ***MLH1* methylation** ☐ ***MGMT***

Fellow/Pathologist Review:

Percentage tumor: _____

Signature: _____ **Date:** _____

Notes:

LAB USE ONLY: Received Date: _____ Time: _____ Initials: _____

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare law. When ordering tests for which Medicare reimbursement will be sought, physicians should order only those individual tests that are necessary for the diagnosis and treatment of a patient, rather than for screening purposes. **Form revised 02-2022**