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

PATIENT DEMOGRAPHIC INFORMATION

PATIENT DEMOGRAPHIC AREA

NAME (LAST, FIRST, MI)

FAHC - MRN | DOB | SEX ☐ M ☐ F

SOCIAL SECURITY NO.

BILLING PROVIDER

ACCOUNT INFORMATION / REPORT CODE	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 _____ - _____

☐ NO INSURANCE BILL PATIENT
FILL IN LINES 1-2

BILLING INFORMATION AREA

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. An ABN should be obtained if testing does not meet policy criteria.

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:

LAB USE:

ACC#

MEDIA (Check √)

- ☐ **Na Heparin**
- ☐ **BM Media**
- ☐ **EDTA**
- ☐ **Formalin**

Time in Formalin _____:_____

- ☐ **RPMI**
- ☐ **Hanks Solution**
- ☐ **Other:**

Other Testing:

MUST HAVE AT LEAST 2 PATIENT IDENTIFIERS ON EACH PATIENT SAMPLE

BONE MARROW MORPHOLOGIC EVALUATION

Bone Marrow Reflex Testing is orderable only when UVMMC Hematopatholgy is reviewing aspirate and/or biopsy slides internally.
To order ONLY Cytogenetics and/or Flow Cytometry please use order selection in the column on the right.

√	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 Media or NaHep)
	CLL FISH Panel
	t(9;22) BCR/ABL Chronic Myelogenous Leukemia (CML)
	t(15;17) PML/RARA Acute Promyelocytic Leukemia (APL)
	Other _____

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