



Cancer Whole Exome Sequencing & Transcriptome for Sohn Conference Foundation Only

Must be filled out completely.

A. PATIENT INFORMATION:			B. ORDERING PHYSICIAN INFORMATION:		
LAST NAME:	FIRST NAME:	M.I.:	LAST NAME:	FIRST NAME:	M.I.:
DATE OF BIRTH:	MRN:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	INSTITUTION:	NPI #:	
ADDRESS:			ADDRESS:		
CITY, STATE & ZIP:			CITY, STATE & ZIP:		
HOME PHONE:	WORK PHONE:		TELEPHONE NUMBER:	FAX NUMBER:	
INSURANCE INFORMATION <i>PLEASE PROVIDE A COPY OF INSURANCE CARD:</i>					
NAME OF POLICY HOLDER:			DATE OF BIRTH:		
RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER					
NAME & ADDRESS OF INSURANCE COMPANY:					
POLICY NUMBER:			GROUP NUMBER:		
SECONDARY INSURANCE CARRIER:			NAME OF POLICY HOLDER:		
POLICY NUMBER:			GROUP NUMBER:		
PREAUTHORIZATION: If health insurance preauthorization is required, check here if preauthorization is pending: <input type="checkbox"/>					

NOTE TO HEALTH CARE PRACTITIONER: It is New York State Law and Columbia University Policy that an informed consent is obtained prior to performing genetic predisposition testing and maintained in the patient's medical record. Please use the appropriate disease/gene information/informed consent sheet, ensure that the patient/legal guardian understands its contents, and obtain the person's signature. If the patient consents to having the sample retained in the lab for greater than 60 days, please include a copy of the consent form with this requisition. **I have obtained a signed informed consent to perform genetic testing in accordance with New York State Civil Rights Law, 79-L, and the informed consent is retained in the patient's medical record.:**

C. SPECIMEN INFORMATION:		
Tumor Information		
<input type="checkbox"/> PERIPHERAL BLOOD Lavender top tube, 3-5ml, room temperature or refrigerated.	<input type="checkbox"/> BONE MARROW Lavender top tube, > 5ml, at room temperature.	
<input type="checkbox"/> FFPE SAMPLE 1 Paratube of shavings, 30 unstained slides, and 1 H&E. Ship at room temperature.	<input type="checkbox"/> DNA/RNA Extracted in a CLIA laboratory.	
<input type="checkbox"/> PATHOLOGY SPECIMEN ID NUMBER: _____ REVIEWING PATHOLOGIST: _____ Pathologist's Name (Printed)		
REPORT ATTACHED: <input type="checkbox"/> PATHOLOGY REPORT - SOLID TUMOR <input type="checkbox"/> FLOW/BONE MARROW BIOPSY/ CYTOGENETICS/ASPIRATE REPORT - LIQUID TUMOR		
DATE SPECIMEN COLLECTED:	TIME: AM PM	DATE ORDERED:
Normal Tissue Information		
NORMAL SPECIMEN TYPE /SOURCE: _____		

D. CLINICAL INFORMATION:	
DIAGNOSIS:	NEOPLASTIC CONTENT:
ICD 10 CODE(S):	OTHER RELEVANT CLINICAL INFORMATION:

LAB USE ONLY: Tissue contains _____% of Tumor	Reviewer's Name (Printed) _____	Reviewer's Signature _____
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