NAME

MR #

DOB

GENDER

Boston Medical Center

DMP Laboratory Requisition Form

670 Albany Street, Rooms 348 Tel. (617) 414-7916/4275; Fax. 617-414-5315

Following is to be filled by the requesting oncologist/pathologist.

Date: ________________

BMC Path# ______________________

Brief clinical history and indication for the test requested: ______________________

____

Please check the box for test from the list below:

☐ **lgH gene rearrangement by PCR**

☐ **T-cell receptor gamma gene rearrangement by PCR**

☐ **Bcl-1/IgH translocation by PCR**

☐ **Bcl-2/IgH translocation by PCR**

☐ **Microsatellite Instability (MSI) Assay by PCR**

☐ **BRAF V600E Mutation by PCR**

☐ **KRAS codon 12/13 Sequencing by PCR**

☐ **EGFR mutation analysis (exons 18, 19, 20, 21) by Fragment and sequencing by PCR**

☐ **FISH: ALK Break-apart by Abbott FISH kit**

☐ **FISH: c-myc/IGH (8:14) translocation**

☐ **Other (please specify)**

Requesting Physician/Pathologist (important! please print and sign):

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Directions for request Submission:

Fax requisition form to 617-414-5315 (DMP laboratory).

Form 999846 (rev 2/2013)