

**Chromosome Study,
Leukemic Blood (4280H) data form**

Patient name: _____

Patient DOB: _____

Patient MRN: _____

Date of procedure: _____

Provider: _____

Diagnosis code (ICD10): _____

Reason for referral: _____

Chromosome study:

- Hold-Contact lab within 72 hours
- No
- Yes

Chromosome result priority:

- N/A
- Routine
- Stat

FISH:

- Yes
- No

FISH Result Priority:

- N/A
- Routine
- Stat

Leukemic FISH Studies (may check/enter more than one option if needed):

- ATM Deletion
11Q22.3/TP53 17p13.1 deletion
- BCR/ABL
1 t(9;22)
- CLL panel
*Full four probe panel: LSI ATM/LSI TP53' LSI D13S319/ LSI 13q34/CEP 12,
LIS IGH/LSI CCND1 XT and LSI SEC63/LSI C-MYC*
- CLL prognostic panel
Two probe panel; LSI ATM/LSI TP53 and LSI D13s319/LSI 13Q34/CEP 12
- CLL progressive panel
LSI ATM/ LSI TP53
- PML/RARA
t(15;17)

Physician name: _____

Physician phone number: _____

This form is for data collection only. The information it contains must be included in the electronic order, and the form should not be sent with the specimen to Allina Health Laboratory.