ONCOKIDS® TEST REQUISITION

All information must be completed before sample can be processed.

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
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DOB (MM/DD/YYYY): ___________________________ Gender: ☐ M ☐ F ☐ Unknown

Ancestry: ☐ African American ☐ Central/South American ☐ Native American

☐ Ashkenazi Jewish ☐ Eastern European ☐ Northern European

☐ Asian ☐ Hispanic ☐ Pacific Islander

☐ Carribean ☐ Middle Eastern ☐ Western European

☐ Caucasian ☐ Other (Please specify): ______________________

MRN: ________________________________________

**CLINICAL INFORMATION**

Clinical Diagnosis or Indication for test: __________________________________________________________

Note: Please include a copy of the pathology report with this requisition

**SAMPLE INFORMATION**

Date of Collection (MM/DD/YYYY): ___________________________

Time Collected: __________ ☐ AM ☐ PM Collected By: ___________________________

Specimen ID: ____________________________________________

SAMPLE TYPE (Please select):

☐ BONE MARROW ASPIRATE IN EDTA (lavender top tube)

☐ BLOOD IN EDTA (lavender top tube)

☐ FRESH FROZEN TISSUE ☐ In cryotube or foil ☐ In OCT block

(Must have greater than 50% tumor)

Source: ___________________________ Percent of tumor in sample: ______________

☐ PARAFFIN EMBEDDED TISSUE ☐ FFPE block(s) ☐ Scrolls (H&E slide required)

(Must have greater than 50% tumor)

Block ID Number(s): ___________________________

☐ Concentration: ______________(ug/mL) Volume ____________(uL)

Patient has had a transfusion? ☐ Yes ☐ No If “Yes,” please contact the lab.

**REPORTING INFORMATION**

Hospital/Laboratory Name: ________________________________

Contact Name: ________________________________________

Address: _______________________________________________

City: __________________________ State: ________ Zip Code: __________

Phone: __________________________ Fax:_____________________

Email: __________________________

☐ Send Duplicate Report to:

Physician: _____________________________________________

NPI: __________________________________________________

Address: _______________________________________________

City: __________________________ State: ________ Zip Code: __________

**BILLING INFORMATION**

Referring Institution

CHLA Account Number:* ________________________________

Hospital/Laboratory Name: _______________________________

Address: _______________________________________________

City: __________________________ State: ________ Zip Code: __________

Accounts Payable Contact Name: _________________________

Phone: __________________________ Fax:_____________________

Email: ________________________________________________

**TEST ORDER**

☐ OncoKids® Cancer Panel (CPT Codes 81455, G0452) (interpretation included)

SEE PAGE 2 FOR SAMPLE REQUIREMENTS AND SHIPPING INSTRUCTIONS.

For Internal Use Only:

Date Received: ______/______/______ Time Received: ______:____ AM /PM

Technician: ____________________________________________

Rev 091018
SHIPPING AND HANDLING INSTRUCTIONS

BONE MARROW ASPIRATE:
1. Bone marrow aspirate and leukemic blood should be collected in EDTA (lavender top tube) and shipped same day (overnight) at 4°C.
   Child or Adult: 1-2 mL
   **DO NOT FREEZE.** Bone marrow aspirate and leukemic blood must be received in laboratory within 2 days of collection.

BLOOD:
1. Collect blood in EDTA (lavender top tube). Child or Adult: 3-5mL
2. Ship sample same day (overnight) at 4°C. **DO NOT FREEZE.** Blood must be received in laboratory within 2 days of collection.

PARAFFIN EMBEDDED AND FRESH FROZEN TUMOR TISSUE:
1. Tumor tissue should be snap frozen immediately after surgery and placed in cryopreservation vials, sterile foil, or a cassette.
2. If frozen tissue is not available, send a tissue block.
3. If a tumor block is not available, send 10 scrolls cut at 20 microns in two 1.5 mL tubes and a H&E slide, cut and stained from the adjacent section.
4. Label samples with patient’s first and last name, Date of Birth (DOB), and the surgical number of the tissue.
5. Immediately before shipping, pack frozen vials of tumor in dry ice. Obtain a Styrofoam container with a lid. This container should be large enough to accommodate 5kg of dry ice. Enough dry ice must be used to prevent any possibility of thawing during transport. Obtain a cardboard box and snugly fit the Styrofoam container inside. Fill the Styrofoam container with 5kg of dry ice. Place the frozen sample in the cassette or cryopreservation rube in a plastic biohazard bag. Place the biohazard bag into the dry ice so that the sample is completely covered. Attach the lid to the Styrofoam container and secure with tape.
6. Place this requisition and pathology report(s) in a plastic Ziploc bag. Place the Ziploc bag or envelope on top of the Styrofoam lid but inside of the cardboard box. Secure the cardboard box with tape.

GENERAL INSTRUCTIONS:
1. We will notify you within 72 hours of receipt if we are unable to perform testing due to compromised sample integrity.
2. Please notify us ASAP in writing if you wish to cancel a test. Cancellations cannot be accepted once testing has been initiated.
3. We accept samples Monday through Thursday from 7:00 AM to 4:00 PM PST. We also accept samples on Friday by 11:00 AM PST. All packages should be mailed for receipt by Friday. Holidays and weekends should be taken into consideration before mailing samples.
4. To ensure sample integrity, use of the following delivery priorities is highly recommended.
   - FedEx: First Overnight
   - UPS: Next Day Air Early AM
1. **Your specimen is important to us. Please email the tracking number to PLMTrack@chla.usc.edu at the time of shipment and include contact information to be used in the event your sample is not received.**

BILLING INFORMATION
1. For billing inquiries, please call (877) 543-9522.
2. If you are interested in opening an account with Children’s Hospital Los Angeles, please contact our Laboratory Service Center at (877)543-9522. Please be prepared to provide the following information:
   a. Name of Institution
   b. Address
   c. Phone/Fax Number
   d. Laboratory Contact Name and phone number
   e. Accounts Payable Contact Name and phone number
3. Third party billing is not offered at this time.

CHILDREN’S CONNECT
1. For all other inquiries, please contact our Laboratory Service Center at:
   (877)KIDZ-LAB or (877) 543-9522

CONTACT US
1. For all other inquiries, please contact our Laboratory Service Center at:
   (877)KIDZ-LAB or (877) 543-9522
2. or visit our website at:
   CHLA.org/CPM