

# Form D

Form available online at [www.paml.com](http://www.paml.com) (Forms and Brochures).

Phone: 509-434-1050

## Fluorescence In Situ Hybridization (FISH) Reflex Testing Solid Tumor Specimens

Fax : 509-747-2388

PATIENT NAME	BIRTH DATE	ACCESSION NUMBER
CLINICAL INDICATION	CYTOGENETIC RESULT	

**Testing: Check boxes for specific probes needed.**

Tumor Type	FISH Probes	Locus
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> HER2/CEP17	17q11.2-q12
<input type="checkbox"/> Oligodendroglioma	<input type="checkbox"/> 1p/19q, PTEN, EGFR,, TP16	1p25, 19q13, 10q23, 7p12, 9p21
<input type="checkbox"/> EWING'S SARCOMA	<input type="checkbox"/> EWSR1	22q12
<input type="checkbox"/> LIPOSARCOMA	<input type="checkbox"/> CHOP	12q13
<input type="checkbox"/> LIPOSARCOMA	<input type="checkbox"/> FUS	16p11
LYMPHOMA SUBTYPE:		
<input type="checkbox"/> Anaplastic Large Cell	<input type="checkbox"/> ALK	2p23
<input type="checkbox"/> Burkitt	<input type="checkbox"/> MYC/IGH	t (8;14)(q24;q32)
<input type="checkbox"/> Diffuse Larger Cell	<input type="checkbox"/> BCL2/IGH <input type="checkbox"/> BCL6	t (14;18)(q32;q21) 3q27
<input type="checkbox"/> Follicular	<input type="checkbox"/> BCL2/IGH	t (14;18)(q32;q21)
<input type="checkbox"/> MALT	<input type="checkbox"/> MALT1	18q21
<input type="checkbox"/> Mantle Cell	<input type="checkbox"/> CCND1/IGH	t (11;14)(q21;q32)
<input type="checkbox"/> Uncharacterized	<input type="checkbox"/> IGH	14q32
<input type="checkbox"/> NEUROBLASTOMA	<input type="checkbox"/> MYCN	2p24.1
<input type="checkbox"/> RETINOBLASTOMA	<input type="checkbox"/> RB1	13q14
<input type="checkbox"/> RHABDOMYOSARMA	<input type="checkbox"/> FKHR	13q14
<input type="checkbox"/> SYNOVIAL SARCOMA	<input type="checkbox"/> SYT (SS18)	18q11.2
<input type="checkbox"/> Wilm's Tumor / Aniridia (WAGR)	<input type="checkbox"/> WT1 <input type="checkbox"/> PAX6	WT1 (11p13) deletion PAX6 (11p13) deletion
<input type="checkbox"/> Other recommended probe:		

**Please indicate the desired test(s) and fax your request back to the lab with a physician signature. An addendum report will be issued when the FISH analysis is complete.**

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Test Ordered By:	Phone:	Date:
Physician Signature:	CPT CODES TO BILL: 88291x _____ 88271x _____ 88273x _____ 88283x _____	