



# Fluorescent in Situ Hybridization (FISH) REFLEX TESTING

HEMATOLOGIC NEOPLASTIC SPECIMENS

**Sacred Heart Cytogenetics Laboratory**  
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**PAML**  
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<b>PATIENT NAME / ACCESSION NUMBER</b>
<b>CLINICAL INDICATION / CYTOGENETIC RESULT</b>
Fluorescent in situ hybridization (FISH) analysis with DNA probes can be performed to evaluate this specimen further for the presence of a specific abnormal cell clone. The probes can be used to detect clones in the non-dividing cell population, further characterize a known cytogenetic anomaly, diagnose a cryptic anomaly, or test for the presence of residual disease. If additional testing is clinically indicated, please circle the considered/known diagnosis and the probe(s) desired. Probes can be ordered singly or as panels where indicated. There is an additional charge for this test.

Diagnosis	FISH Probes
<input type="checkbox"/> ANLL/AML – FAB type: _____ Choose one or more:	<input type="checkbox"/> AML/ETO, <input type="checkbox"/> PML/RARA, <input type="checkbox"/> ELL/ENL, <input type="checkbox"/> CBF- $\beta$ , <input type="checkbox"/> MLL
<input type="checkbox"/> CML	<input type="checkbox"/> BCR/ABL1
<input type="checkbox"/> CLL/SLL Panel Optional:	<input type="checkbox"/> ATM,D13S319,TP53,CEP12 <input type="checkbox"/> CCND1/IGH
<input type="checkbox"/> Lymphoma Subtype: _____	<input type="checkbox"/> CCND1/IGH, <input type="checkbox"/> BCL2/IGH, <input type="checkbox"/> MALT, <input type="checkbox"/> BCL6, <input type="checkbox"/> IGH dual <input type="checkbox"/> MYC/IGH, ALK
<input type="checkbox"/> ALL-Pediatric	<input type="checkbox"/> TEL/AML1, <input type="checkbox"/> MLL, <input type="checkbox"/> BCR/ABL1, <input type="checkbox"/> TP16, <input type="checkbox"/> CEP4, 10, 17
<input type="checkbox"/> ALL-Adult	<input type="checkbox"/> BCR/ABL1, <input type="checkbox"/> ELL/ENL, <input type="checkbox"/> MLL
<input type="checkbox"/> MDS/AML Panel	<input type="checkbox"/> EGR1, D7S486, CEP8, D20S108
<input type="checkbox"/> MM/MGUS Panel If IGH +, FGFR3 -, reflexes additionally to:	<input type="checkbox"/> TP53, D13S319, MLL, FGFR3/IGH <input type="checkbox"/> cMAF/IGH, CCND1/IGH
<input type="checkbox"/> Hypereosinophilia / Eosinophilia	<input type="checkbox"/> CHIC2
<input type="checkbox"/> Bone Marrow Transplant (opposite sex donor)	<input type="checkbox"/> CEPX, CEPY
<input type="checkbox"/> Other recommended probe:	

<b>Please indicate the desired test(s) and fax your request back to the lab with a physician signature.</b> <b>An addendum report will be issued when the FISH analysis is complete.</b>	
<b>TESTS ORDERED BY:</b>	<b>DATE:</b>
<b>CPT CODES TO BE BILLED FOR THIS TEST:</b>	
88291 $\times$ 1, 88283 $\times$ _____, 88275 $\times$ _____, 88271 $\times$ _____	