MT. SINAI HOSPITAL LABORATORY DEPARTMENT OF PATHOLOGY
MOUNT SINAI LABORATORY • ICAHN SCHOOL OF MEDICINE
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MOLECULAR PATHOLOGY REQUISITION FORM

FULL NAME (LAST, FIRST – PLEASE PRINT)		DOB	AGE	GENDER ☐ Male ☐ Female
ADDRESS	CITY		STATE	ZIP
PATIENT MRN	REFERRING PHYSICIAN		DATE	

SPECIMEN		ICD-10	LAB USE ONLY
☐ Whole Blood	☐ Fresh Tissue, Site:_____		
☐ Bone Marrow	☐ Body Fluid, Site: _____		
☐ Lymph Node	☐ Paraffin Slides/Block		
	Case#_____		

Clinical History / Reason For Test Request

_____

_____

TEST(S) REQUESTED

T Cell Gene Rearrangement:

☐ TRG (T Cell Receptor Gamma) PCR
☐ TRB (T Cell Receptor Beta) PCR

B Cell Gene Rearrangement:

☐ IGH (Ig Heavy Chain) PCR
☐ IGK (Ig Light Chain, Kappa) PCR

SOLID TUMORS:

☐ **NGS Solid Tumor HotSpot Panel**
Specific Genes/Mutations of Interest
- ☐ *KRAS*
- ☐ *EGFR*
  - ☐ T790M
- ☐ *ALK/ROS1 translocations* (FISH-REFLEX)
- ☐ *BRAF*
- ☐ *IDH1/IDH2*
- ☐ *PIK3CA*
- ☐ *CTNNB1* *(Beta Catenin)*

☐ HPV Genotyping by PCR (16/18 & other types)
☐ *MGMT* Methylation analysis
☐ *MYD88* L265P

Other Tests

_____
_____
_____
_____
_____

*****REFERRING PHYSICIAN CONTACT INFORMATION*****
(Required for testing!)

NAME:_____

ADDRESS: _____Email_____

PHONE:_____FAX:_____