

SSM Cardinal Glennon Children's Medical Center

Patient History To Accompany Specimens

Molecular-Cytogenetics Laboratory
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Patient Name: _____ DOB: _____ Age: _____
Sex: _____ Medical Record #: _____
Attending Physician: _____ Phone/Fax: _____
Inpatient? Outpatient? Bill directly? Please attach direct outpatient bill insurance information.

Type of Sample:
 Blood Bone (Marrow Core) Oncology Blood Blast % _____ Lymph Node
 a Mass Type Pleural Effusion Solid Tumor, type: _____
Collected on (date): _____ at (time) _____ AM PM (circle one)

Cancer Testing:
Diagnosis: Considered Confirmed
 AML
 ALL Pre-B Other _____
 CL CML CLL
 Myeloproliferative Disorder (MPS)
 Myelodysplastic Syndrome (MDS)
 Lymphoma
 Hodgkin's
 NHL B T Other _____
 Solid Tumor

Disease Status:
 Pretreatment
 Post-treatment: Possible remission
 Chemotherapy
 Radiation
 Transplant Donor sex: ____

FISH:
 No
 Yes _____

Why is chromosome study ordered? **(Must be filled out.)**
 Diagnosis/staging
 Follow-up disease status post therapy
 Assess engraftment following transplant
Previous testing? Here Elsewhere Results: _____