Boston Medical Center
DMP Laboratory Requisition Form
670 Albany Street, Rooms 348  Tel. (617) 414-7916/4275; Fax. 617-414-5315

Following is to be filled by the requesting oncologist/pathologist.

Date: ____________________

BMC Path# ____________________

Brief clinical history and indication for the test requested: ____________________

Please check the box for test from the list below:

☐ IgH gene rearrangement by PCR

☐ T-cell receptor gamma gene rearrangement by PCR

☐ Bcl-1/IgH translocation by PCR

☐ Bcl-2/IgH translocation by PCR

☐ Microsatellite Instability (MSI) Assay by PCR

☐ BRAF V600E Mutation by PCR

☐ KRAS codon 12/13 Sequencing by PCR

☐ EGFR mutation analysis (exons 18, 19, 20, 21) by Fragment and sequencing by PCR

☐ FISH: ALK Break-apart by Abbott FISH kit

☐ FISH: c-myc/IGH (8:14) translocation

☐ Other (please specify)

Requesting Physician/Pathologist (important! please print and sign):

Directions for request Submission:
Fax requisition form to 617-414-5315 (DMP laboratory).