UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

Translational Genomics Laboratory
655 W. Baltimore St. BRB 7-037
Baltimore, MD 21201
410 706 3339
CAP# 8017554
CLIA# 21D2027356

| Individual Authorized to Complete Test Requisition | Report to Name (ordering physician) **Please Print** | | | Additional Report Recipient |
|---|---|---|---|---|
| Authorized Person's Signature | Date | Phone # | Fax # | Email |

**Test Requested:**

□ Confirmation of Research Finding (CRF)

□ *CYP2C19* Genotyping

□ Cytogenomic Microarray (tech only/wet bench)

□ *FLT3* ITD & TKD Analysis

□ *IDH1* R132 & *IDH2* R140 & R172 Sanger Sequencing

□ Myeloid Malignancy Mutation NGS Panel

**Report to Address: Results *will be sent to this address***

**Indication for Testing/Clinical Details/Comments:**

**ICD-10 codes** _____ _____ _____ _____

| Patient Name or Sample ID | Gender | Date of Birth | MRN | Date/Time Collected | Sample Type | TGL Sample Number |
|---|---|---|---|---|---|---|
| | | | | | | |

**Shaded Area for Translational Genomics Laboratory Use Only**

Date & Time Received: _____ Package Integrity: Acceptable? ☐ Yes ☐ No

Received/Numbered By: _____ Sample Condition: Acceptable? ☐ Yes ☐ No