

**NEOPLASIA IFISH SUPPLEMENTAL REQUEST FORM**

Cytogenetics Laboratory University of Washington Medical Center Phone: 206-598-4488

Re: \_\_\_\_\_

Please **CHECK** the appropriate section, **SIGN** below and **FAX** to (206)-598-2610

IFISH panel for:	IFISH Probes	Loci
AML (M2, M3, M4)	t(8;21), t(15;17), inv(16)	RUNX1T1(ETO)/RUNX1, PML/RARA, CBFβ
AML (M2, M3, M4) <i>Extended</i>	inv(3), t(8;21), t(9;22), rea(11q23), t(15;17), inv(16)	EVI1, RUNX1T1(ETO)/AML1, BCR/ABL1/ASS, MLL, PML/RARA, CBFβ
B-cell Lymphoma	rea(3q27), rea(8q24.1), t(11;14), t(11;18), t(14;18), <i>reflex</i> t(8;14), t(14;18) (MALT)	BCL6, MYC/IGH/CEN8, MYC, CCND1/IGH, API2/MALT1, IGH/BCL2, IGH/MALT1
CLL (or SLL)	del(6q), del(11q), t(11;14), +12, del(13q), del(17p)	MYB, ATM, CCND1/IGH, CEN12, D13S319/13q34, TP53
MDS/MPD (or CMML)	inv(3), del(5), del(7), +8, del(13q), del(20)	EVI1, EGR1/D5S23, D7S486/CEN7, CEN8, D13S319/13q34, D20S108
Multiple Myeloma	t(4;14), +5, +9, t(11;14), t(14;16), del(13q), +15, del(17p)	FGFR3/IGH, D5S23/D5S721, CEN9, CCND1/ IGH, IGH/MAF, D13S319/13q34, CEN15, TP53/CEN17
T-cell ALL	del(9p), rea(11q23)	CDKN2A(P16)/CEN9, MLL

Individual FISH Probes	Loci	Individual FISH Probes	Loci
rea(2p23)	ALK	+12	CEN12
inv(3)	EVI1	rea(12p13)	ETV6(TEL)
rea(3q27)	BCL6	t(12;21)	ETV6(TEL)/RUNX1
rea(4q12)	SCFD2,LNX, PDGFRA/KIT	del(13q)	D13S319/13q34
t(4;14)	FGFR3/IGH	rea(13q14)	FOXO1
-5 or del(5)	EGR1/D5S23	rea(14q11)	TCR alpha/delta (TCRA/D)
rea(5q33)	PDGFRB	rea(14q32)	TCL1 <u>OR</u> IGH (Please specify)
del(6q)	MYB	t(14;16)	IGH/MAF
-7 or del(7)	D7S486/CEN7	t(14;18)	IGH/BCL2
rea(7q34)	TCRB	t(14;18)	IGH/MALT1
+8	CEN8	t(15;17)	PML/RARA
rea(8q24.1)	MYC	inv(16)	CBFβ
t(8;14)	MYC/IGH/CEN8	del(17p)	TP53/CEN17
t(8;21)	RUNX1T1(ETO)/RUNX1	rea(18q11)	SYT
del(9p)	CDKN2A(P16)/CEN9	del(20)	D20S108
t(9;22)	BCR/ABL1/ASS* (Do not order if PCR test is negative)	rea(22q12)	EWSR1
del(11q)	ATM	Urovysion	CEN3, CEN7, 9p21, CEN17
rea(11q23)	MLL	+5, +9, +15	D5S23/D5S721, CEN9, CEN15
t(11;14)	CCND1/ IGH	Other	Specify:
t(11;18) <u>OR</u> t(14;18)	API2/MALT1 <u>OR</u> IGH/MALT1		

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician Name - printed

Patient Name:

DOB:

MR#: