

<p><b>PATIENT INFORMATION</b> (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name _____ First _____ MI _____</p> <hr/> <p>Address _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>Hospital/Physician Office Patient ID # _____ Accession # _____</p> <p>MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.</p> <p><b>INSURANCE BILLING INFORMATION</b> (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p><b>BILL TO:</b> <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p><b>PATIENT STATUS:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p><b>ABN:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>PRIMARY:</b> <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child</p> <hr/> <p>Subscriber Last Name _____ First _____ MI _____</p> <hr/> <p>Beneficiary / Member # _____ Group # _____</p> <hr/> <p>Claims Address _____ City _____ State _____ Zip _____</p> <p><b>SECONDARY:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please attach)</p> <hr/> <p><b>DIAGNOSIS CODE (REQUIRED)</b> ICD-10 Codes 1. _____ 2. _____ 3. _____</p> <hr/> <p><b>DIAGNOSIS</b> _____</p> <hr/> <p><b>CLINICAL HISTORY</b> _____</p> <hr/>	<p style="text-align: center;"><b>CLIENT INFORMATION</b></p> <hr/> <p><b>ORDERING PHYSICIAN CONTACT</b></p> <p>Physician Name _____</p> <p>Physician NPI# _____</p> <p>Physician Phone _____</p> <p>Physician Email _____</p> <p><input type="checkbox"/> Call Results to phone number: ( _____ ) _____</p> <p><input type="checkbox"/> Fax report to: ( _____ ) _____</p> <hr/> <p><b>SPECIMEN INFORMATION</b></p> <p>Collection Date: ____/____/____ Time: _____</p> <p>Body Site: _____ Client Case #: _____</p> <p>Specimen ID# _____</p> <p><input type="checkbox"/> Blocks: Unstained _____ Stained _____</p> <p><input type="checkbox"/> Slides: Unstained _____ Stained _____</p> <p><input type="checkbox"/> Other: _____</p> <hr/> <p><b>Time of formalin fixation required:</b> (Check one)</p> <p><input type="checkbox"/> Less than 6 hours</p> <p><input type="checkbox"/> 6-48 hours: Specify _____</p> <p><input type="checkbox"/> Greater than 48 hours</p> <p><input type="checkbox"/> Cold Ischemia Time (breast markers)</p> <p><b>Fixation type for this Specimen:</b> _____</p> <p><input type="checkbox"/> Electron Microscopy (must be in Glutaraldehyde)</p> <p><input type="checkbox"/> Direct Immunofluorescence (DIF)</p> <p><input type="checkbox"/> Cell Pellet: EGFR Mutational Analysis (ASPCR)</p> <p><input type="checkbox"/> Paraffin Block: ALK (FISH)</p> <p><input type="checkbox"/> Paraffin block: Immunohistochemistry (Indicate Stain)</p> <p><input type="checkbox"/> Paraffin Block: EGFR Mutational Analysis (ASPCR)</p> <p><input type="checkbox"/> Paraffin block: ER/PR (IHC)</p> <p><input type="checkbox"/> Paraffin block: HER2 (FISH)</p> <p><input type="checkbox"/> Paraffin block: KRAS Mutational Analysis (ASPCR)</p> <p><input type="checkbox"/> Paraffin block: BRAF Mutational Analysis (ASPCR)</p> <p><input type="checkbox"/> Paraffin block: HER2 (Erb-b2) HER2 (IHC)</p> <p><input type="checkbox"/> ThinPrep Cytology Slide: ALK (FISH)</p> <hr/> <p><b>CONSULTATION ON PREPARED SLIDES/BLOCKS</b></p> <p><b>Biopsy: Specimen Types(s)/Sources(s):</b></p> <p>A) _____</p> <p>B) _____</p> <p>C) _____</p> <p style="text-align: center;"><b>REQUIRED GYN SPECIMEN INFORMATION</b></p> <p>LMP _____</p> <p>PAP _____</p> <p>DRUGS/CHEMO Rx _____</p> <p>OP _____</p> <p>RAD Rx _____</p> <hr/> <p><b>Chromosome Analysis</b></p> <p>_____ Cytogenetics / Chromosome Study, Products of Conception</p> <p>_____ Cytogenetics / Chromosome Study, Tissue Other: _____</p> <p><i>Note: Transport in Saline, Formalin is unacceptable; Stability: 48 Hours Refrigerated</i></p> <hr/> <p><b>SPECIAL REQUEST:</b> _____</p> <hr/>
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