

<p>PATIENT INFORMATION (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> <hr/> <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>INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p>BILL TO: <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p>PATIENT STATUS: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p>PRIMARY: <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>SECONDARY: <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach)</p> <hr/> <p>DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____</p> <hr/> <p>CLINICAL INFORMATION <input type="checkbox"/> See Attached Letter <input type="checkbox"/> Copy of Pathology Report: (REQUIRED)</p> <p>Brief Clinical History: _____</p> <hr/> <p>PATHOLOGY CONSULTATION REQUEST</p> <p><input type="checkbox"/> Pathology Consultation Please check below for a Preferred Subspecialty Group</p> <p>In addition to what has been ordered, the Cleveland Clinic Pathologist is authorized to add other testing as needed to assist in evaluation.</p> <p><input type="checkbox"/> Breast <input type="checkbox"/> Cardio <input type="checkbox"/> Cyto <input type="checkbox"/> Derm <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> GYN <input type="checkbox"/> Head/Neck</p> <p><input type="checkbox"/> Hepatic <input type="checkbox"/> Heme <input type="checkbox"/> Kidney <input type="checkbox"/> Neuro <input type="checkbox"/> Ortho <input type="checkbox"/> Pulmonary <input type="checkbox"/> Soft Tissue</p> <p><input type="checkbox"/> Special Stain(s) Requested: _____</p>	<p>CLIENT INFORMATION</p> <hr/> <p>ORDERING PHYSICIAN CONTACT</p> <p>Physician Name _____</p> <hr/> <p>Physician NPI# _____</p> <hr/> <p>Physician Phone _____</p> <hr/> <p>Physician Email _____</p> <p><input type="checkbox"/> Call Results to phone number: (_____) _____</p> <p><input type="checkbox"/> Fax report to: (_____) _____</p> <p><input type="checkbox"/> Additional fax report to: (_____) _____</p> <hr/> <p>SPECIMEN INFORMATION</p> <p>Collection Date: ____/____/____ Time: _____</p> <hr/> <p>Body Site: _____ Client Case #: _____</p> <hr/> <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>FREQUENTLY REQUESTED TESTS</p> <p><input type="checkbox"/> Amyloid Typing by Mass Spectrometry</p> <p><input type="checkbox"/> Direct Immunofluorescence</p> <p><input type="checkbox"/> DNA Fingerprinting (specimen identification, floaters)</p> <p><input type="checkbox"/> Electron Microscopy (tissue must be fixed in glutaraldehyde)</p> <p><input type="checkbox"/> Other: _____</p>
<p>FLOW CYTOMETRY</p> <p><input type="checkbox"/> Leukemia/Lymphoma Panel <i>RLLLIP</i></p> <p><input type="checkbox"/> Lymphoma Panel for Tissue/Fluid <i>RLLYMP</i></p> <p><input type="checkbox"/> PNH, High Sensitivity, FLAER, Peripheral Blood Only <i>PNHPNL</i></p>	<p>MOLECULAR TESTING ON TISSUE SPECIMENS</p> <p>BREAST</p> <p><input type="checkbox"/> HER2 (FISH)</p> <p>COLON/GI</p> <p><input type="checkbox"/> MSI-Microsatellite Instability Analysis (PCR) <i>MSI-3</i></p> <p><input type="checkbox"/> BRAF Mutation (NGS) <i>BRAF</i></p> <p><input type="checkbox"/> KRAS (NGS) <i>KRAS</i></p> <p><input type="checkbox"/> HER2 Gastric (FISH)</p> <p>GLIOMA</p> <p><input type="checkbox"/> Malignant Glioma (1p, 19q) (FISH)</p> <p><input type="checkbox"/> MGMT Methylation with Pyrosequencing</p> <p>LUNG</p> <p><input type="checkbox"/> ALK for NSCLC (FISH) <i>ALKFSH</i></p> <p><input type="checkbox"/> ALK ThinPrep for NSCLC (FISH) <i>FSHTPA</i></p> <p><input type="checkbox"/> EGFR Mutation, Tissue (NGS) <i>EGFRTI</i></p> <p><input type="checkbox"/> EGFR Mutation, Cell Pellet (NGS) <i>EGFRCP</i></p> <p><input type="checkbox"/> KRAS Mutation (NGS) <i>KRAS</i></p> <p><input type="checkbox"/> BRAF Mutation (NGS) <i>BRAF</i></p> <p>LYMPHOMA</p> <p><input type="checkbox"/> B Cell Clonality – <i>IGH</i> and <i>IGK</i> (PCR) <i>BCBMD</i></p> <p><input type="checkbox"/> FISH for Aggressive B-cell Lymphoma Panel <i>FABCEL</i></p> <p><input type="checkbox"/> T Cell Clonality – <i>TCRB</i> and <i>TCRG</i> (PCR) <i>TCBMD</i></p> <p><input type="checkbox"/> BCL6 (3q27) Rearrangement (FISH)</p> <p><input type="checkbox"/> MALT1 (18q21) Rearrangement (FISH)</p> <p><input type="checkbox"/> MYC (8q24) Rearrangement (FISH)</p> <p>MELANOMA</p> <p><input type="checkbox"/> BRAF V600 <i>BRAF</i></p> <p><input type="checkbox"/> Melanoma Panel (FISH) <i>CMFISH</i></p> <p>SOFT TISSUE</p> <p><input type="checkbox"/> EWSR1 (22q12) Rearrangement (FISH)</p> <p><input type="checkbox"/> SYT (18q11) Translocation (FISH)</p> <p><input type="checkbox"/> FOXO1A (FKHR) (13q14) Translocation (FISH)</p> <p><input type="checkbox"/> DDIT3 (CHOP) 12q13 Translocation (FISH)</p> <p><input type="checkbox"/> MDM2 Amplification (FISH)</p>