

PATHOLOGY

CYTOGENETICS & GENOMICS

NEOPLASIA TEST REQUEST FORM

For UW Pathology use

MRN:	Accession #
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1 Patient Information	First Name	MI	Last Name
	Sex	DOB	SSN
	Patient Address		
	City	State	Zip
	Patient Phone #	Outside Facility Patient ID	

2 Requesting Institution	Institution Name		
	Institution Address		
	City	State	Zip
	Person Completing Form		
	Phone	Fax	

3 Send Reports to	Requesting Physician (primary):	Phone	Fax	NPI#
	Referring Physician/Surgeon:	Phone	Fax	NPI#
	Referring Pathologist:	Phone	Fax	NPI#
	Additional reports to:	Phone	Fax	NPI#

4 Billing Information	Payment Options: <input type="checkbox"/> Patient Insurance* (If outpatient) <input type="checkbox"/> Self-Pay (No insurance) <input type="checkbox"/> Institution/Client Billing <input type="checkbox"/> Split Billing / Medicare* (Pro to Patient, Tech to Client)							
	*Medicare Billing policy does not permit tech claims on laboratory testing for hospital inpatients/outpatients. These tech charges will be billed to the requesting institution.							
	Primary Insurance				Secondary Insurance			
	ID/Policy #		Group #		ID/Policy #		Group #	
	Insurance Address			Phone	Insurance Address			Phone
	City/State/Zip				City/State/Zip			
Insured's Name		DOB	Relation to Pt:		Insured's Name		DOB	Relation to Pt:

Note: For sample collection requirements see <http://www.UWPathology.org/clinical/cytogenetics>

5 Specimen Type	Date obtained:
<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Bone Core Biopsy <input type="checkbox"/> Leukemic Blood <input type="checkbox"/> Fresh or Frozen Tumor (Site: _____) <input type="checkbox"/> Paraffin Blocks/Slides (Site: _____) <input type="checkbox"/> Urine <input type="checkbox"/> Other: _____	

6 Diagnosis or Indication for Testing
ICD-10 Code: _____
Disease Phase: <input type="checkbox"/> Pre-treatment or Relapse <input type="checkbox"/> Post-treatment <input type="checkbox"/> Post-transplant

7 Test(s) Requested	<input type="checkbox"/> STAT <input type="checkbox"/> ROUTINE												
<input type="checkbox"/> G-banded chromosome analysis and karyotyping <input type="checkbox"/> Neoplasia Cytogenomic Microarray Analysis (CMA / CGH / CGAT / SNP Array) <input type="checkbox"/> Single Neoplasia IFISH (specify locus or gene) _____ If: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal reflex to _____ <input type="checkbox"/> Neoplasia IFISH Panel (check one) See http://www.pathology.washington.edu/clinical/cytogenetics/ for loci included in panels. <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> AML</td> <td><input type="checkbox"/> Eosinophilia</td> <td><input type="checkbox"/> T-cell ALL</td> <td><input type="checkbox"/> Bladder Cancer</td> </tr> <tr> <td><input type="checkbox"/> MDS / MPD (or CMML)</td> <td><input type="checkbox"/> CLL or SLL</td> <td><input type="checkbox"/> Adult B-cell ALL</td> <td><input type="checkbox"/> Glioblastoma</td> </tr> <tr> <td><input type="checkbox"/> B-cell Lymphoma</td> <td><input type="checkbox"/> Multiple Myeloma</td> <td><input type="checkbox"/> Childhood ALL</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>	<input type="checkbox"/> AML	<input type="checkbox"/> Eosinophilia	<input type="checkbox"/> T-cell ALL	<input type="checkbox"/> Bladder Cancer	<input type="checkbox"/> MDS / MPD (or CMML)	<input type="checkbox"/> CLL or SLL	<input type="checkbox"/> Adult B-cell ALL	<input type="checkbox"/> Glioblastoma	<input type="checkbox"/> B-cell Lymphoma	<input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/> Childhood ALL	<input type="checkbox"/> Other: _____	
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Ordering Provider Signature Required	
Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services policies found at http://pathology.washington.edu/clinical/servicerequest	
Signature	Date