UW Medicine
PATHOLOGY
CYTOGENETICS & GENOMICS

RESET FORM

1959 NE Pacific St, **Room NW-125**, Seattle, WA 98195
Phone: 206-598-4488 | Fax: 206-598-2610
UWPathology.org/clinical/cytogenetics

NEOPLASIA TEST REQUEST FORM

For UW Pathology use	
MRN:	Accession #

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: ☐ Patient Insurance* (If outpatient) ☐ Self-Pay (No insurance) ☐ Institution/Client Billing ☐ 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 www.pathology.washington.edu/patient-care/cytogenetics-collection

⑤ Specimen Type

Date obtained:

- ☐ Bone Marrow
- ☐ Bone Core Biopsy
- ☐ Leukemic Blood
- ☐ Fresh or Frozen Tumor (Site: _____)
- ☐ Paraffin Blocks/Slides (Site: _____)

  Surgical Specimen # _____

  Block # _____

  Send marked H&E image
- ☐ Urine
- ☐ Other: _____

⑥

ICD-10 Code: _____

Disease Phase: ☐ Pre-treatment or Relapse ☐ Post-treatment ☐ Post-transplant

***** SEE PAGE 2 FOR TESTS *****

7 Test(s) Requested

☐ **STAT** ☐ ROUTINE

☐ G-banded chromosome analysis and karyotyping

☐ Neoplasia Cytogenomic Microarray Analysis (CMA / CGH / CGAT / SNP Array)

☐ Single Neoplasia IFISH (specify locus or gene) _____ If: ☐ Normal

☐ Abnormal reflex to _____

☐ Neoplasia IFISH Panel (check one) *See* ***www.pathology.washington.edu/patient-care/cytogenetics-neoplasia-testing*** *for loci included in panels.*

☐ AML	☐ Eosinophilia	☐ T-cell ALL	☐ Bladder Cancer
☐ MDS / MPD (or CMML)	☐ CLL or SLL	☐ Adult B-cell ALL	☐ Glioblastoma
☐ B-cell Lymphoma	☐ Multiple Myeloma	☐ Childhood ALL	☐ Other: _____

☐ FusionPlex (check one) (Specify any genes of interest _____)

☐ Solid Tumor Test ☐ Pan-Heme Test ☐ 2-10 Gene Test ☐ Single Gene Test

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**

Patient Insurance Billing Consent

I authorize the Clinical Cytogenomics Laboratory (CCL) to release to my designated insurance carrier, health plan, or third party administrator the information on this form and any other information provided by my health care provider necessary for reimbursement. I assign and authorize insurance payments to CCL. I understand my insurance carrier may not approve and reimburse my medical genetic services in full due to usual and customary rate limits, benefit exclusions, coverage limits, lack of authorization, medical necessity, or otherwise. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State or Federal law. A duplicate or faxed copy of this authorization is considered the same as the original document.

Patient Signature	**Date**