UW Medicine
LABORATORY MEDICINE & PATHOLOGY

Reset Form

1959 NE Pacific St, Room NW-125, Seattle, WA 98195
Phone: 206-598-4488 | Fax: 206-598-2610
https://dlmp.uw.edu/patient-care/cytogenetics
http://uwcpdx.org/clinical-genomics-laboratory/

NEOPLASIA TEST REQUEST FORM

For UW Pathology use
Accession #

1 Patient Information

Legal First Name	MI	Legal Last Name
Sex Assigned at Birth	Gender Identity	DOB
Patient Address		
City	State	Zip
Patient Phone #	Patient MRN	

2 Requesting Institution

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

3 Send Reports to

Ordering Provider	Phone	Fax	NPI#
Clinical Care Provider	Phone	Fax	NPI#
Additional reports to	Phone	Fax	NPI#

4 Billing Information

Payment Options: ☐ Patient Insurance* (If outpatient) ☐ Institution/Client Billing ☐ Split Billing / Medicare* (Pro to Patient, Tech to Client) ☐ Self-Pay

**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.*

If billing insurance: Patient signature required on back. Please attach a copy of face sheet and front/back of card(s).

Primary Insurance			Secondary Insurance		
Subscriber Name	DOB	Relation to Pt	Subscriber Name	DOB	Relation to Pt

5 Specimen Type

Date obtained:

Time 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
- ☐ DNA (Extracted from_____)
- ☐ RNA (Extracted from_____)
- ☐ Other_____

6 Diagnosis or Indication for Testing

ICD-10 Code_____

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

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

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Legal First Name	MI	Legal Last Name
DOB		

7 Test(s) Requested

☐ **STAT** ☐ ROUTINE

☐ G-banded chromosome analysis and karyotyping

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

☐ Abnormal reflex to_____

☐ Neoplasia IFISH Panel (check one) *See* ***https://dlmp.uw.edu/patient-care/cytogenetics-neoplasia-testing*** *for loci included in panels.*

☐ AML ☐ Eosinophilia ☐ T-cell ALL

☐ MDS / MPD (or CMML) ☐ CLL or SLL ☐ Adult B-cell ALL

☐ B-cell Lymphoma ☐ Multiple Myeloma ☐ Childhood ALL ☐ Other:_____

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

☐ Neoplasia Microarray Analysis with DNA Methylation Profiling

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

Solid Tumor Test: ☐ Whole Panel ☐ 2-10 Genes ☐ Single Gene

Pan-Heme Test: ☐ Whole Panel ☐ 2-10 Genes ☐ Single Gene

8 Ordering Provider Signature Required

Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services policies found at https://dlmp.uw.edu/patient-care/servicerequest

Signature	Date

9 Patient Insurance Billing Consent

I authorize the Clinical Genomics Laboratory (CGL) 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 CGL. 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