

# REQUISITION COMPLETION INSTRUCTIONS

## Right Side of Requisition

\*Required element

\*\*Required if requesting billing to other than the referring institution; rather than completing the section, you may attach paperwork that contains the requested information.

1. Do not write or type in this section
2. Enter institution name, department (if applicable), and shipping address for the referring facility. *Note: This is where the primary copy of the report(s) will be mailed and where specimens will be returned\**
3. Enter phone number for the referring institution or referring pathologist/physician\*
4. Enter FAX number for the referring institution; this is where the report will be faxed\*
5. Enter name of the ordering pathologist or physician\*
6. Enter the ordering pathologist's/physician's NPI number\*
7. Enter patient name (Last, First, MI)\*
8. Enter patient's social security number
9. Enter patient's date of birth (MM/DD/YYYY)\*
10. Check off appropriate box to indicate gender of patient\*
11. Check off box to indicate if the patient is an "inpatient", "outpatient", or "non-hospital patient"
12. Enter address of patient
13. Enter city, state, and zip code of patient
14. Enter phone number of patient
15. Enter medical record number of patient
16. Enter patient number
17. Enter name of physician who is treating the patient\*
18. Enter treating physician's NPI number\*
19. Check the box if you want PhenoPath to mail and fax a copy of the report(s) to the treating physician
20. Enter the phone number of the treating physician; required if the box to mail/fax a copy of the report is checked
21. Enter the FAX number of the treating physician; required if the box to mail/fax a copy of the report is checked
22. Enter the institution name of the treating physician
23. Enter the address of the treating physician; required if the box to mail/fax a copy of the report is checked
24. Enter the city, state, and zip code of the treating physician; required if the box to mail/fax a copy of the report is checked
25. Check the box to indicate who PhenoPath should bill for services rendered\*
26. Enter the referral/authorization number\*\*
27. Enter the patient's Medicare number if applicable\*\*
28. ICD9 code\*
29. Check the box to indicate if there is an attached Advance Beneficiary Notice (ABN) \*\*
30. Enter name of health plan\*\*
31. Enter address of health plan\*\*
32. Enter the policy or certificate number for the patient's insurance policy\*\*
33. Enter the group or plan number for the patient's insurance policy\*\*
34. Enter the name of the insured\*\*
35. Enter the relationship of the patient to the insured\*\*
36. Check the box if the patient is insured by more than one policy
37. Enter the name of the person who is completing the form\*
38. Enter the date the form was completed\*
39. Enter the phone number of the person completing the form\*

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### PATHOLOGY REQUISITION FORM

**THIS SECTION FOR PHENOPATH USE ONLY**

## PATH

1

**REQUESTING INSTITUTION NAME & ADDRESS**

2

Phone  FAX

**Ordering Pathologist/Physician**

Name  NPI #

**PATIENT INFORMATION**

Name (Last, First, MI)

SSN #  DOB   Male  Female

11  Inpatient  Outpatient  Non-Hospital Patient

Address

Phone

Medical Record #  Pt #

**TREATING PHYSICIAN**

Name  NPI #

19  Mail/Fax add'l copy of report to treating physician  
Complete information REQUIRED BELOW

Phone  Fax

Institution

Address

City, State Zip

**BILLING INFO (Must be provided or institution will be billed)**  
Please complete or attach copy of insurance card

**BILL:**  Ins  Medicare  Medicaid (WA DSHS only)  Institution  Pt 25

Referral/Authorization #

Medicare #  ICD-9 #

Advance Beneficiary Notice 29  Yes (provide copy)  No

Healthplan

Address

Policy/Cert #  Group/Plan #

Name of Insured  Relationship

Secondary Insurance  Yes (Please attach separate sheet)  No 36

**REQUIRED**

Person completing form


Date  Phone

# REQUISITION COMPLETION INSTRUCTIONS

## Left Side of Requisition

### \*Required element

Note: For ER, PR, and HER2 testing, we require the type of fixative and duration of fixation information completed (see red box)

 <p>Toll-free: (888) 92-PHENO P (206) 374-9000 F (206) 374-9009</p>	<p>1</p>
<p><b>CLINICAL SPECIMEN INFORMATION</b></p>	<p>1. Enter the name of hospital or institution where the specimen was collected*</p>
<p>Hosp/Inst where specimen collected: _____</p>	<p>2. Enter the date the specimen was collected/date of procedure*</p>
<p>Collection Date _____ Collection Time _____</p>	<p>3. Enter the time the specimen was collected</p>
<p>Specimen ID _____ Block # / Sublabel _____ Tissue Source(s) _____</p>	<p>4. Enter the accession number of each specimen (list on separate lines if multiple accession numbers) *</p>
<p>_____</p>	<p>5. Enter the specimen sublabel</p>
<p><input type="checkbox"/> Paraffin blocks: Tissue block(s) _____ Cell block(s) _____</p>	<p>6. Enter the tissue source of the specimen*</p>
<p><input type="checkbox"/> Formalin <input type="checkbox"/> Bouin's <input type="checkbox"/> B5 <input type="checkbox"/> Prefer <input type="checkbox"/> Michel's (skin IF TM) <input type="checkbox"/> Other</p>	<p>7. Check the box(s), as appropriate to indicate the specimens being sent; enter the number of blocks/slides, as appropriate</p>
<p><input type="checkbox"/> Slides: Unstained _____ Stained _____</p>	<p>8. Check the box to indicate if you want all specimens tested or if you want PhenoPath pathologist to determine the best block for testing; required if sending multiple specimens</p>
<p><input type="checkbox"/> Smears: Air-dried _____ Fixed _____ Stained _____</p>	<p>9. Enter pertinent clinical history, the diagnosis under consideration, and/or request; required if test(s) being requested are not otherwise marked on the form</p>
<p>Multiple specimens submitted: <input type="checkbox"/> Test all <input type="checkbox"/> Select best block</p>	<p>10. Check the box to indicate if you desire a PhenoPath pathologist to determine medically necessary tests to perform or if you desire only the specific test(s) you have requested to be performed and interpreted*</p>
<p><b>CLINICAL HX / DX UNDER CONSIDERATION / REQUEST</b></p>	<p>11. Check off test(s) being requested; if you are unable to find the applicable box(s) or are unsure which box(s) to check, write in the test(s) being requested in the Clinical Hx/Dx Under Consideration/Request box (see #9 above)*</p>
<p>_____</p>	
<p><input type="checkbox"/> Perform &amp; interpret tests determined medically necessary by PhenoPath MDs</p>	
<p><input type="checkbox"/> Perform &amp; interpret only test(s) as requested</p>	
<p><b>BREAST MARKER STUDIES</b></p>	
<p><input type="checkbox"/> ER/PR <input type="checkbox"/> ER <input type="checkbox"/> PR <input type="checkbox"/> p53 <input type="checkbox"/> MIB-1</p>	
<p><b>HER2 TESTING</b> (if equivocal by IHC or FISH, we reflex to other method)</p>	
<p><input type="checkbox"/> HER2 by IHC <input type="checkbox"/> HER2 by FISH (FISH0001)</p>	
<p><input type="checkbox"/> Reflex to Topoisomerase II<math>\alpha</math> (TOP2A/CEP17 FISH0017) if HER2 +</p>	
<p><input type="checkbox"/> Alternative chrom 17 normalization probes for HER2 eval: SMS/RARA (FISH0022); TP53/CEP17 (FISH0024)</p>	
<p><input type="checkbox"/> Myoepithelial markers to r/o invasive carcinoma</p>	
<p><input type="checkbox"/> If invasive CA, run the above selected markers</p>	
<p><input type="checkbox"/> E-cadherin to differentiate ductal from lobular CA</p>	
<p><input type="checkbox"/> R/O basal-like breast CA</p>	
<p><b>BREAST MARKER STUDIES FIXATION (ASCO/CAP REQUIREMENT)</b></p>	
<p>Fixative: <input type="checkbox"/> Formalin <input type="checkbox"/> Other _____</p>	
<p>Fixation duration: &gt; 6 &amp; &lt; 48 hours <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><b>IMMUNOHISTOCHEMISTRY PANELS</b></p>	
<p><input type="checkbox"/> Pituitary panel <input type="checkbox"/> Other _____</p>	
<p><input type="checkbox"/> Amyloid analysis/typing _____</p>	
<p><input type="checkbox"/> Microsatellite instability (MMR) by IHC _____</p>	
<p><b>FLUORESCENCE IN SITU HYBRIDIZATION (FISH) &amp; CISH</b></p>	
<p><input type="checkbox"/> HER2/CEP17 (PathVysionTM) _____ # FISH0001</p>	
<p><input type="checkbox"/> TOP2A/CEP17 _____ # FISH0017</p>	
<p><input type="checkbox"/> TP53/CEP17 _____ # FISH0024</p>	
<p><input type="checkbox"/> SMS/RARA _____ # FISH0022</p>	
<p><input type="checkbox"/> EGFR/CEP7 _____ # FISH0016</p>	
<p><input type="checkbox"/> EWSR1 (22q12) translocations (breakapart) _____ # FISH0004</p>	
<p><input type="checkbox"/> SS18 (SYT) translocations (breakapart) _____ # FISH0006</p>	
<p><input type="checkbox"/> MDM-2/SE12 _____ # FISH0023</p>	
<p><input type="checkbox"/> 1p36/19q13 - Oligodendroglioma panel _____ # FISH0013</p>	
<p><input type="checkbox"/> CEP-X/CEP-Y _____ # FISH0012</p>	
<p><input type="checkbox"/> Hydatid. Mole Panel (CEP-17 FISH + p57 IHC + MIB IHC) # PANL9105</p>	
<p><input type="checkbox"/> EBV (EBER1 mRNA BY ISH) _____ # CISH0001</p>	
<p><b>PCR MUTATION ANALYSES</b></p>	
<p><input type="checkbox"/> KRAS &amp; BRAF _____ # PANL9105 <input type="checkbox"/> EGFR _____ # PCR0007</p>	
<p><input type="checkbox"/> BRAF _____ # PCR0004 <input type="checkbox"/> JAK2 _____ # PCR0003</p>	
<p><input type="checkbox"/> KRAS _____ # PCR0005</p>	