



ResourcePath, LLC
45945 Trefoil Ln #175
Sterling, VA 20166
571-375-0755
Medical Director: D. Ashley Hill, MD
hill@resourcepath.net

For Lab Use Only: Received: _____ Accession number: _____ Number of samples: _____

ResourcePath Next Generation Sequencing Mutation Analysis Requisition

Patient Information

Date of Request (mm/dd/yyyy): ___/___/___

Patient Name (last, first, mi): _____

Address: _____ Phone: _____

Birthdate (mm/dd/yyyy): ___/___/___ Sex: ___M ___F Race/Ethnicity: _____

Reporting/Billing Information

Requesting Physician/Genetic Counselor: _____

Institution: _____ Mailing Address: _____

Billing Address (if different from mailing): _____

Phone Number: _____ Fax number: _____ Fax results: ___yes ___no

E-mail address: _____ E-mail results: ___yes ___no

Testing Information

Please check all that apply

DICER1 Mutation Analysis FOXL2- Cys134Trp Somatic Mutation Analysis TP53 Mutation Analysis

Reason for testing (diagnosis):

Tumor or cyst diagnosis: _____ Site of tumor/cyst: _____

Date of Diagnosis: _____

Relative of patient- please indicate mutation if known: _____

Asymptomatic/presymptomatic testing Other: _____

Sample Information

Please check all that apply:

Blood - Date Collected: ___/___/___ Time Collected: _____

Saliva/buccal - Date Collected: ___/___/___ Time Collected: _____

FFPE Tissue blocks/scrolls/slides - Date Collected: ___/___/___ Estimated Tumor Content: _____ Block ID: _____

DNA (Indicate source): _____

Other: _____ (please contact laboratory before sending a specimen marked "other")

O Please include relevant clinical information and signed genetic testing consent along with this requisition form.

X Physician Signature: _____

CPT Code: 81407 (Molecular procedure level 8 for NGS of DICER1)

Please note that our laboratory only does institutional billing. For questions about billing and test ordering please call 571-375-0755 or email info@resourcepath.net