

Test Requisition

Patient Information								
Name								
<table border="1"> <tr> <td style="width: 33%;">Last</td> <td style="width: 33%;">First</td> <td style="width: 33%;">Middle</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>			Last	First	Middle	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last	First	Middle						
<input type="text"/>	<input type="text"/>	<input type="text"/>						
DOB								
<table border="1"> <tr> <td style="width: 33%;">MM</td> <td style="width: 33%;">DD</td> <td style="width: 33%;">YEAR</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>			MM	DD	YEAR	<input type="text"/>	<input type="text"/>	<input type="text"/>
MM	DD	YEAR						
<input type="text"/>	<input type="text"/>	<input type="text"/>						
Sex								
<input type="text"/>								
Ethnicity								
<input type="text"/>								
Indications for Testing:								
<input type="text"/>								
Reporting Information								
Requesting Physician/Genetic Counselor								
<input type="text"/>								
NPI:								
<input type="text"/>								
Institution								
<input type="text"/>								
Mailing Address								
<input type="text"/>								
Street								
<input type="text"/>								
City								
<input type="text"/>								
State								
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Zip								
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Phone								
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Fax								
<input type="text"/>								
Email								
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Billing								
Institution (if different from above)								
<input type="text"/>								
Accounts Payable Contact								
<input type="text"/>								
Phone								
<input type="text"/>								
E-mail								
<input type="text"/>								
Billing Address (if different from above)								
<input type="text"/>								
Street								
<input type="text"/>								
City								
<input type="text"/>								
State								
<input type="text"/>								
Zip								
<input type="text"/>								

Sequencing Test Menu
<input type="checkbox"/> DICER1 Germline Testing - (CPT 81407) <input type="checkbox"/> DICER1 Tumor Testing - (CPT 81407) <input type="checkbox"/> FOXL2 Tumor Testing - (CPT 81407) <input type="checkbox"/> TP53 Germline Testing - (CPT 81407) <input type="checkbox"/> TP53 Tumor Testing - (CPT 81407) <input type="checkbox"/> Oncomine Comprehensive v3 (Hotspots/Full Genes/CNVs and Fusions) - (CPT 81455) <input type="checkbox"/> Oncomine Comprehensive v3 RNA (Fusions Only) - (CPT 81455) <input type="checkbox"/> Oncomine Comprehensive v3 DNA (Hotspots/Full Genes/CNVs only) - (CPT 81455)
ctDNA Test Menu (Available March 2019)
<input type="checkbox"/> DICERDx (CPT 81479) <input type="checkbox"/> H3F3A (CPT 81479) <input type="checkbox"/> HIST1H3B (CPT 81479)
Sample Type
<input type="checkbox"/> FFPE (>30% tumor) <input type="checkbox"/> Block <input type="checkbox"/> Slides <input type="checkbox"/> Scrolls Specimen ID: _____ Source: _____ %Tumor: _____ <input type="checkbox"/> Frozen/Fresh Tissue (>30% tumor) Collection Date: _____ Specimen ID: _____ Source: _____ %Tumor: _____ <input type="checkbox"/> Blood in EDTA (lavender top) Collection Date: _____ <input type="checkbox"/> Streck Cell Free DNA BCT Collection Date: _____ <input type="checkbox"/> Saliva/Buccal Swabs Collection Date: _____ <input type="checkbox"/> CSF Collection Date: _____ Time: _____ Centrifugation Date: _____ Time: _____ <input type="checkbox"/> Plasma in EDTA Collection Date: _____ Time: _____ Centrifugation Date: _____ Time: _____ <i>Note: DNA and RNA submitted must be extracted in a CLIA certified lab</i> CLIA#: _____ <input type="checkbox"/> DNA Collection Date: _____ Source: _____ <input type="checkbox"/> RNA Collection Date: _____ Source: _____