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 Information

Requesting Physician/Genetic Counselor: _____NPI: _____

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

Facility Billing Information (Please include Institution's Billing Information even if Patient's insurance information is included)

Accounts Payable Contact: _____ Phone Number: _____ Email: _____

Email: _____ Billing Street Address: _____ City: _____ State:_____

Zip Code: _____

◯ Please select if billing should be processed through patient's insurance rather than the ordering facility.

Patient's Insurance Information

Primary Insurance Company: _____ Member ID/ Policy #: _____

Group Number: _____ Client Relationship to Insured: _____

Insured's Name: _____ Insured's Phone Number: _____

Insured's Date of Birth (mm/dd/yyyy): ____/____/_____ Insured's Sex: ____M ____F

Insured's Street Address: _____ Insured's City: _____ Insured's Sate: _____

Insured's Zip Code: _____

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Testing Information
Please check all that apply

◯ DICER1 Germline Testing (CPT 81407) ◯ DICER1 Tumor Testing (CPT 81407) ◯ FOXL2 Tumor Testing (CPT 81407)

◯ TP53 Germline Testing (CPT 81407) ◯ TP53 Tumor Testing (CPT 81407)

Reason for testing (diagnosis):
Tumor or cyst diagnosis: _____ Site of tumor/cyst: _____

Date of Diagnosis: _____

◯ Relative of patient- please indicate mutation if known:_____

◯ Asymptomatic/pre-symptomatic testing ◯ Other: _____

Sample Information
Please check all that apply:

◯ *FFPE (>30% tumor)*
- □ Tissue blocks
- □ Scrolls
- □ Slides

Number of Samples: _____
Date Collected: ___/ ___/ ____
% Tumor: _____
Block ID(s): _____

◯ *Frozen/Fresh Tissue (>30% tumor)*
- □ Fresh Tissue
- □ Frozen Tissue

Date Collected: ___/ ___/ ____
Number of Samples: _____
Source: _____
%Tumor: _____
Specimen ID(s): _____

◯ *Blood in EDTA (Lavender Top)*
Number of Samples: _____
Date Collected: ___/ ___/ ____
Time Collected: _____

◯ *Saliva/Buccal*
Number of Samples: _____
Date Collected: ___/ ___/ ____
Time Collected: _____

◯ *DNA or RNA*
- □ DNA
- □ RNA

Number of Samples: _____
Date Collected: ___/ ___/ ____
Source: _____
Lab's CLIA Number: _____

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

Physician Signature: _____