

Molecular Diagnostics Requisition



VERIPATH LABORATORIES

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CLIA #45D-0659587, CAP #2723201

www.veripathlabs.com

ACCOUNT INFORMATION

Account name: _____
Address: _____ City: _____ State: _____
Zip code: _____ Ph: _____ Fax: _____

REQUIRED ORDER INFORMATION

BILL TO: Facility / Client
 Patient / 3rd party – Billing information must be provided

Patient Name: (Last, First, Middle) _____

Mother's Name: (if infant) _____

Date of Birth: _____ Sex: _____ Patient ID / MR#: _____

Hospital Inpatient Y / N _____ Collection Date: _____ Collection Time: AM _____ PM _____

Ordering Physician (Full Name): _____ NPI: _____
PRINT NAME

Physician Signature: _____
REQUIRED FOR MEDICARE/MEDICAID PATIENTS

Phone: _____ Pager: _____ FAX: _____

Clinical Indication for Tests Ordered: _____

SPECIMEN INFORMATION

- Whole Blood (EDTA preferred)
- Plasma (EDTA preferred)
- Swab Endocervical Urethral
- ThinPrep® (Must be Endocervical)
- Sorted Cells, source: _____
- Fresh Tissue, source: _____
- Fixed Paraffin Embedded Tissue
- Source: _____ Fixative: _____
- Other: _____
- Bone Marrow (EDTA preferred)
- CSF

TESTS REQUESTED

MOLECULAR ONCOLOGY

- B-Cell Clonality PCR
- T-Cell Clonality PCR
- BCL1/IGH: t(11;14) PCR
- BCL2/IGH: t(14;18) PCR (mbr, mcr)
- BCR/ABL: t(9;22) quant. (p210 only) [CML]
- WBC Count: _____
- BCR/ABL: t(9;22) qual. (p210, p190) [CML] [ALL]
- Loss of Heterozygosity (LOH); 1p/19q fragment analysis
- JAK2 V617F mutation analysis
- BRAF mutation analysis
- KRAS mutation analysis
- EGFR mutation analysis

TRANSPLANT ANALYSIS

- STR Pre-Transplant Analysis
- Donor name _____
- Recipient name _____
- STR Post-Transplant Analysis
- Please provide dates of all previous transplants
- _____

OTHER TESTING

- Microsatellite DNA for specimen contamination assessment

PATIENT/3RD PARTY BILLING INFORMATION

ICD-9 Code(s) _____

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) available at: www.veripathlabs.com or by calling customer service at 214-645-7057 or toll free 877-887-8136 Signed ABN included

ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle) _____ Date of Birth: _____

Patient's relationship: Self Spouse Dependent Other
Responsible Party Address: (street, city, State, zip) _____

Sex: _____ Phone: _____

Employer's Name: _____ Employer's Phone: _____

Insurance Co. Name: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____

Policy #: _____ Group #: _____

Medicare HMO Other Medicaid PPO
Member ID#: _____

Referral Authorization/Precertification #: _____
Name: _____ Date/Time: _____

INFECTIOUS DISEASE TESTS

- Chlamydia trachomatis (CT) and Neisseria gonorrhoeae (NG) PCR
- Cytomegalovirus (CMV) PCR, quantitative
- Epstein Barr Virus (EBV) PCR, quantitative
- Hepatitis C Virus (HCV) RT-PCR, quantitative
- Human Papillomavirus, Cervical High Risk (HPV)
- Human Herpes Virus 6 (HHV-6) PCR, qualitative only
- Human Herpes Virus 6 (HHV-6) PCR, qualitative with reflex to quantitative
- Human Herpes Virus 7 (HHV-7) PCR, qualitative
- Human Herpes Virus 8 (HHV-8, KSHV) PCR, qualitative
- Parvovirus B-19 PCR, qualitative
- Varicella Zoster Virus (VZV) PCR, qualitative

GENETIC MUTATION ANALYSIS

- Patient Ethnicity/Race: _____
- Factor 2 (Prothrombin) mutation (20210G-A)
 - Factor 5 Leiden mutation
 - MTHFR mutations (677C-T, 1298A-C)

VERIPATH USE ONLY	Transport Container:	Total # of specimens: _____	Transport Conditions:	Destination: <input type="checkbox"/> Other _____	Initials:
	<input type="checkbox"/> Yellow <input type="checkbox"/> Green <input type="checkbox"/> Purple <input type="checkbox"/> Syringe <input type="checkbox"/> Conical <input type="checkbox"/> Red <input type="checkbox"/> Blue <input type="checkbox"/> Cup <input type="checkbox"/> Trans Tube <input type="checkbox"/> Block <input type="checkbox"/> Slides <input type="checkbox"/> Formalin <input type="checkbox"/> Other: _____		<input type="checkbox"/> Frozen <input type="checkbox"/> Slushy <input type="checkbox"/> Refrig <input type="checkbox"/> Room Temp	<input type="checkbox"/> Coag <input type="checkbox"/> Cytogen <input type="checkbox"/> HemePath <input type="checkbox"/> Flow <input type="checkbox"/> Hist <input type="checkbox"/> Mol Dx	