Molecular Diagnostics

ACCOUNT INFORMATION

Account name: ______________________________

Address:______________________ **City:**______________ **State:**________

Zip code:__________ **Ph:**________________ **Fax:**__________________

Molecular Diagnostics Laboratory
2330 Inwood Road, Suite EB3.304
Dallas, Texas 75235
LAB PHONE: 214-648-0960
LAB FAX: 214-648-0967
CUSTOMER SERVICE: 214-633-5227
CLIA #: 45D0861764
CAP #: 2664213

CLINICAL LABORATORY SERVICES

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:

Phone: | Pager: | FAX:

Clinical Indication for Tests Ordered:

PATIENT/3RD PARTY BILLING INFORMATION

ICD-10 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-10 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:

SPECIMEN INFORMATION

☐ Whole Blood (EDTA preferred)
☐ Plasma (EDTA preferred)
☐ ThinPrep® (Must be Endocervical)
☐ Serum
☐ Bone Marrow (EDTA preferred)
☐ CSF
☐ Swab in Viral Media
☐ Urine
☐ Sorted Cells, source: ______________________
☐ Fixed Paraffin Embedded Tissue
Source: ______________ Block # : ______________
☐ Other: ______________________________

TESTS REQUESTED

MOLECULAR ONCOLOGY

☐ B-Cell Clonality PCR
☐ T-Cell Clonality PCR
☐ BRAF mutations
☐ EGFR mutations by sequencing
☐ EGFR mutations, FDA approved PCR (FFPE)
☐ ERBB2 mutations, lung cancer
☐ IDH1/IDH2 mutations
☐ FLT3 mutation
☐ KIT in melanoma
☐ KRAS mutation analysis
☐ LOH for 1p/19q brain tumors
☐ MEK1 mutations
☐ NRAS mutations
☐ PIK3CA mutations
☐ TP53 mutations
☐ Microsatellite instability (MSI) by PCR

CANCER MUTATION PANELS

☐ Colon: KRAS, NRAS, BRAF
☐ Lung: EGFR,KRAS, PIK3CA, ERBB2, BRAF, NRAS, MEK, AKT
☐ Melanoma: BRAF, C-KIT, NRAS
☐ 50-gene Cancer Mutation Panel by NGS

INFECTIOUS DISEASE by PCR

☐ BK viral load
☐ Chlamydia and Gonorrhoeae, Urine or Thin Prep
☐ CMV viral load
☐ EBV viral load
☐ HCV viral load
☐ HPV high risk with genotyping, cervical
☐ HSV1 and HSV2
☐ VZV
☐ HHV-6 (HHV-6A qualitative; HHV-6b quantitative)
☐ Vaginal Panel - BV, Candidiasis, Trichamoniasis

TRANSPLANT ANALYSIS

☐ Pre-Transplant STR analysis
Donor Name______________________________
Recipient Name____________________________
☐ Post-Transplant STR Analysis

GENETIC MUTATIONS Ethnicity____________________

☐ Factor II (Prothrombin) 20210 G>A G20210A
☐ Factor 5 Leiden G1691A
☐ MTHFR 677 C>T and 1298 A>C
C677T and A1298C (C665T and A1286C)

SPECIMEN CONTAMINATION ASSESSMENT

☐ Mixed or contaminated FFPET (slides)

LAB USE ONLY

Transport Container: **Total # of specimens:**_____
___Yellow ___Green ___Purple ___Syringe ___Conical ___Red ___Blue ___Cup
___Trans Tube ___Block ___Slides ___Formalin ___Other:____________

Transport Conditions:
☐ Frozen ☐ Slushy
☐ Refrig ☐ Room Temp

Destination: ☐ Other__________
☐ Coag ☐ Cytogen ☐ HemePath
☐ Flow ☐ Hist ☐ Mol Dx

Initials: