

TEST REQUEST FORM

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1) PATIENT INFORMATION:

Patient Name: _____ DOB: MM/DD/YYYY
Last First MI
 Patient ID or Medical Record #: _____
 Address: _____
Street City State ZIP
 Reference Lab or Order #: _____
 Telephone: _____ SSN: _____ Sex: M F

2) BILLING INFORMATION:

Check one box for billing type and fill out all accompanying information. Attach a copy of the front and back of insurance card(s).

Bill Patient Visa MasterCard
 Name on Credit Card: _____
 Credit Card #: _____
 Exp. Date: MM/YY Security Code: _____
 Secondary Insurance: Yes No
If you would like us to bill secondary insurance, you must attach a copy of the front and back of the secondary insurance card.

Bill Client
 Bill Medicare > Patient Medicare #: _____
 Bill Private: HMO PPO Medical Group IPA
 Insured ID #: _____
 Relationship to Insured: Self Spouse Dependent Legal Partner
 Primary Insurance/Health Plan Name: _____
 Primary Insurance Address: _____
Street
 City State ZIP
 Primary Insurance Telephone: _____

Attach one specimen label to each Slide or Block

3) ORDERING INFORMATION:

ORDERING PHYSICIAN: _____ Address: _____
Street
 City State ZIP
 Telephone: _____ Fax: _____
 E-mail Address: _____
 Provider #: _____
 ID/License #: _____ NPI #: _____

Signature of Ordering Physician: X
 Date: MM/DD/YYYY

4) SAMPLE INFORMATION:

Please complete all fields.

Primary Diagnosis: Breast Cancer Other: _____
 ICD-9 Code: _____
 Date of Surgery: MM/DD/YYYY Specimen Tissue ID#: _____
 HER2 Status: Positive Negative Indeterminate Unknown
 Sample Type: Slides Block
 Date Block Pulled From Archive: MM/DD/YYYY

Return Block to: Same as Submitting Pathologist
 Contact Name: _____
 Address: _____
Street
 City State ZIP
 Telephone: _____
 E-mail Address: _____
 Please Attach Pathology Report. Is Report Attached? Yes No

5) SUBMITTING INFORMATION:

Physician/Pathologist Name: _____ E-mail Address: _____
 Address: _____
Street
 City State ZIP
 Telephone: _____ Fax: _____
 Additional Physician/Pathologist to Receive Report: _____
 Address: _____
Street City State ZIP
 Telephone: _____ Fax: _____

INTERNAL USE ONLY: # Slides Received: _____ # Blocks Received: _____
 Initials: _____ Date: MM/DD/YYYY

DATE/TIME STAMP: