

Molecular Diagnostics Requisition



VERIPATH LABORATORIES

ACCOUNT INFORMATION

Client Name/Account Number: _____

Client Address: _____

City/State/Zip: _____

Client Phone: _____ Client FAX: _____

2110 Research Row, Suite 221
 Dallas, Texas 75235
 PHONE: 214-645-7057
 Toll Free: 877-887-8136
 FAX: 214-645-7035
 CLIA #45D-0659587, CAP #2723201

www.veripathlabs.com

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: _____ NPI: _____

Phone: _____ Pager: _____ FAX: _____

PATIENT/3RD PARTY BILLING INFORMATION

ICD-9 Code(s) _____

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) on reverse side. Signed ABN included

ICD-9 Codes applicable to each and every test requested should come 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: _____

Clinical Indication for Tests Ordered: _____

SPECIMEN INFORMATION

Bone Marrow Urethral swab **Respiratory Specimens:**
 CSF Whole blood Sputum
 Endocervical swab Sorted Cells Bronchoalveolar lavage
 Lymph node Urine Tracheal aspirate
 Plasma
 Other: _____

Fixative: _____ Anticoagulant: _____

Patient Ethnicity/Race: _____

INDIVIDUAL TESTS

MOLECULAR ONCOLOGY

- B-Cell Clonality PCR, JH gene rearrangement [M/BCLON]
- BCL1/IGH: t(11;14) PCR [M/BCL1]
- BCR/ABL: t(9;22) mRNA PCR, quant. (p210) [CML] [M/BCRABLQT]
- BCR/ABL: t(9;22) mRNA PCR, qual. (p210) (p190) [CML] [ALL] [M/BCRABLQL]
- IGH/BCL2: t(14;18) PCR (mbr) (mcr) [M/BCL2]
- Loss of Heterozygosity (LOH): 1p/19q fragment analysis [M/LOH]
- T-Cell Clonality PCR, Gamma gene rearrangement [M/TCLON]

GENETIC MUTATION ANALYSIS

- Factor 2 (Prothrombin) mutation (20210G-A) [M/PROTH]
- Factor 5 Leiden mutation [M/F5LEID]
- MTHFR mutations (677C-T, 1298A-C) [M/MTHFR]

TRANSPLANT ANALYSIS

- STR Pre-Transplant Analysis [M/STRPRE]
 Donor name _____
 Recipient name _____
- STR Post-Transplant Analysis [M/STRPOST]

INFECTIOUS DISEASE TESTS

- Chlamydia trachomatis* (CT) and *Neisseria gonorrhoeae* (NG) PCR [M/CTNG PCR]
- Cytomegalovirus (CMV) PCR, quantitative [M/CMV PCR]
- Epstein Barr Virus (EBV) PCR, quantitative [M/EBV PCR]
- Hepatitis C Virus (HCV) PCR, quantitative [M/HCV QT]
- Human Papillomavirus (HPV) [M/HPV]
- Human Herpes Virus 6 (HHV-6) PCR, qualitative only [M/HHV6 QL]
- Human Herpes Virus 6 (HHV-6) PCR, qualitative with reflex to quantitative [M/HHV6 QT]
- Human Herpes Virus 7 (HHV-7) PCR, qualitative [M/HHV7 QL]
- Human Herpes Virus 8 (HHV-8, KSHV) PCR, qualitative [M/HHV8 QL]
- Parvovirus B-19 PCR, qualitative [M/PARVOPCR]
- Varicella Zoster Virus (VZV) PCR, qualitative [M/VZOS PCR]

MISCELLANEOUS TESTS (Please call Lab 214-645-7075)

- OTHER: _____
- OTHER: _____

TRANSFUSION/TRANSPLANT HISTORY

Please note transfusion or bone marrow transplant history for 3 months prior to sample collection.

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"/> Aston <input type="checkbox"/> Coag <input type="checkbox"/> Cytogen <input type="checkbox"/> Flow <input type="checkbox"/> Hist <input type="checkbox"/> Mol Dx <input type="checkbox"/> OncoDx	