



CAP #7227931  
CLIA #05D1103594

FAX: 877.320.4743

TEST REQUISITION FORM

| PATIENT INFORMATION |       |                            |                            |
|---------------------|-------|----------------------------|----------------------------|
| NAME                |       |                            |                            |
| FIRST               | MI    | LAST                       |                            |
| ADDRESS             |       |                            |                            |
|                     |       |                            |                            |
| CITY                | STATE | ZIP                        |                            |
| PHONE               |       |                            |                            |
| DOB                 | SEX   | <input type="checkbox"/> M | <input type="checkbox"/> F |
| MEDICAL RECORD #    |       |                            |                            |

| SAMPLE INFORMATION   |        |
|----------------------|--------|
| SPECIMEN ID          |        |
| DATE OF COLLECTION   |        |
| SPECIMEN SITE        |        |
| PRIMARY TUMOR SITE   |        |
| PATHOLOGY DEPARTMENT |        |
| CONTACT NAME         | E-MAIL |
| PHONE                | FAX    |

| HEALTHCARE PROVIDER INFORMATION                       |            |
|---|------------|
| <input type="checkbox"/> REFERRING PHYSICIAN          |            |
|   |            |
| NPI #   |            |
|   |            |
| HOSPITAL/INSTITUTION                                  |            |
| ADDRESS   |            |
|   |            |
| CITY  | STATE ZIP  |
| PHONE   |            |
| EMAIL   |            |
| CONFIDENTIAL FAX NUMBER FOR COMMUNICATION OF RESULTS: |            |
|   |            |
| <input type="checkbox"/> SEND ADDITIONAL REPORTS TO:  |            |
| NAME  | SECURE FAX |
|   |            |

| TEST ORDERED   |  |
|--|--|
| <input type="checkbox"/> HI-RES HER2 FOR BREAST CANCER               |  |
| <input type="checkbox"/> GATA-3 BY IHC FOR BREAST AND BLADDER CANCER |  |
| <input type="checkbox"/> NGS PANEL FOR CRC                           |  |

| TISSUE TYPE   |  |
|---|--|
| <input type="checkbox"/> FFPE TISSUE (SPECIFY TYPE) _____ |  |
| <input type="checkbox"/> WHOLE BLOOD                      |  |
| <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____     |  |

|          |
|----------|
| COMMENTS |
|----------|

| CLINICAL INFORMATION   |  |
|--|--|
| DIAGNOSIS _____  |  |
| TREATMENT HISTORY _____  |  |
|  |  |
| <input type="checkbox"/> IMMUNOHISTOCHEMISTRY (IHC) RESULT _____               |  |
| <input type="checkbox"/> FLUORESCENT IN SITU HYBRIDIZATION (FISH) RESULT _____ |  |

| BILLING INFORMATION  |               |
|--|---------------|
| <input type="checkbox"/> CREDIT CARD <input type="checkbox"/> INSURANCE BILL <input type="checkbox"/> INSTITUTION BILL |               |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |               |
| CARD NUMBER  |               |
| EXP DATE   | SECURITY CODE |
| PRIMARY INSURANCE  |               |
| POLICY #   |               |
| GROUP #  |               |
| NAME OF INSURED  |               |
| NAME OF INSTITUTION TO BE BILLED   |               |
| ADDRESS  |               |
| PHONE  |               |

| SPECIMEN BAR CODES     |  |
|------------------------|--|
| FOR PACIFICDX USE ONLY |  |

| PLEASE ATTACH COPIES OF:  |  |
|---|--|
| <input type="checkbox"/> FRONT AND BACK OF INSURANCE CARD                 |  |
| <input type="checkbox"/> PATHOLOGY REPORTS INCLUDING IHC AND FISH RESULTS |  |
| <input type="checkbox"/> CLINICAL INFORMATION INCLUDING TREATMENT HISTORY |  |
| <input type="checkbox"/> OTHER MOLECULAR TEST RESULTS                     |  |

| ORDER AND AUTHORIZATION                                    |      |
|--|------|
| I CERTIFY THAT THE ORDERED TESTING IS MEDICALLY NECESSARY. |      |
| ORDERING PHYSICIAN SIGNATURE                               | DATE |

| ICD-10 DIAGNOSIS CODES |  |
|------------------------|--|
|                        |  |