The Pathology Center
Methodist Hospital
8303 Dodge Street
Omaha, Nebraska 68114-4199
Phone: 402-354-4541 1-888-432-8980 Fax: 402-354-8806

www.thepathologycenter.org

FAX COMPLETED FORM TO:
FAX: (402) 354-4535 PHONE: (402)-354-4550
ATTN: ROZ

FOR LAB USE ONLY

FIN#: _____

DATE / INITIALS: _____

SLIDES RECEIVED: _____

SLIDES FROM ARCHIVE: _____

ALL INFORMATION IN THIS COLUMN TO BE COMPLETED

REQUESTING PHYSICIAN _____

OFFICE NAME OR FACILITY: _____

_____

ADDRESS: _____

CONTACT PERSON: _____

AUTHORIZED SIGNATURE FOR VERBAL REQUEST:

_____

PHONE NUMBER: _____

FAX NUMBER: _____

REQUEST DATE: _____

☐ **CURRENT INPATIENT** ☐ **OUTPATIENT**
☐ **HAS PATIENT BEEN DISCHARGED IN LAST 14 DAYS**

LEGAL PATIENT NAME: _____
LAST **FIRST** **MI**

☐ **M** ☐ **F** **DOB** / / **SSN #** _____

*****PLEASE ATTACH CURRENT PATIENT DEMOGRAPHICS AND COPIES OF ALL CURRENT INSURANCE CARDS *****

REQUEST FOR TESTING INDICATES PATIENT CONSENT TO RELEASE INFORMATION REGARDING TESTING AS REQUESTED IS ON FILE AT CLIENT FACILITY.

Medicare ABN or Non Medicare Waiver of Liability ☐ **YES** ☐ **NO**

Diagnosis/ICD-10: _____

Preauthorization:

☐ **Completed** ☐ **In-Process** ☐ **Not Required**

Authorization Number: _____

TESTING REQUESTED

Requested Testing

- ☐ DNA (S Phase & Ploidy)
- ☐ HER-2 NEU
- ☐ **BRAF**
- ☐ CANCER TYPE ID
- ☐ **EGFR**
- ☐ EML4 / ALK
- ☐ ER / PR
- ☐ **KRAS**
- ☐ MGMT
- ☐ MMR SCREENING TEST FOR LYNCH SYNDROME
- ☐ ONCOTYPE DX
- ☐ FOUNDATION ONE
- ☐ TARGET NOW (CARIS)
- ☐ 1p19q DELETION
- ☐ P16
- ☐ ROS 1
- ☐ AGENDIA:
  - ☐ BLUEPRINT
  - ☐ MAMAPRINT
  - ☐ OTHER: _____
- ☐ OTHER _____
- ☐ CONSULT
  Slides Requested from _____

☐ STAIN ONLY FOR _____
AND RETURN

ALL TESTING MAY REQUIRE PRE-AUTHORIZATION
CONSULT WITH PATIENT TO OBTAIN INFORMATION
HIGHLIGHTED TESTS REQUIRE PRE-AUTHORIZATION

SURGICAL PATHOLOGY

Completed Reference Lab Requisition with signature and demographics attached

SPECIMEN INFORMATION

Specimen Type: _____

Source: _____

Collected: _____

Previous Case Number: _____

Clinical History (Pre-Op/Post-Op Findings):

_____

LABEL