

### Shipping Address

**Washington University Pathology Services**  
 Clinical Support Office  
 425 S. Euclid Ave., Room 4701  
 MSC 8024-14-4711  
 St. Louis, MO 63110

### Sample drop-off locations:

**Clinical Support Office**  
 509 S. Euclid Ave.  
 4th Floor West Bldg, Room 4711  
 St. Louis, MO 63110  
 Tel: (314) 454-8101  
 (8:00am - 5:00pm)

**Institute of Health (IOH) Core Lab**  
 425 S. Euclid Ave., Room 4701  
 St. Louis, MO 63110  
 Tel: (314) 362-1470  
 AFTER HOURS

### Office use only

Date/Time Received:  
 Accession Number:  
 Technician Initial:

**This requisition has two pages, please complete both pages to ensure testing.**

### PATIENT IDENTIFICATION

### PHYSICIAN Ordering TEST (NPI required)

Patient Status: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Office Visit	Name:
Name Last: First: MI:	Institution:
DOB (mm/dd/yyyy): Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	NPI: Email:
Medical Record # (if applicable):	Address:
Address:	City: State: Zip:
City: State: Zip:	Phone: Fax:
Ethnicity (select all that apply)	Alternative Contact Information:
<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/NW European	Phone: Email:
<input type="checkbox"/> E Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish-Ashkenazi <input type="checkbox"/> Jewish-Sephardic	Notes:
<input type="checkbox"/> Mediterranean <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other	

### SPECIMEN INFORMATION

Date of biopsy: Specimen #	
<b>Paraffin Embedded Tissue</b> <ul style="list-style-type: none"> <li>• Minimum # of unstained slides = 3 per test ordered</li> <li>• Cut at 4-5 microns on positively charged slides</li> <li>• Slides should be stored/ sent overnight at ambient temperature</li> <li>• Must be fixed in 10% neutral buffered formalin</li> <li>• Preferred fixation duration for tissue samples is 6-72 hours</li> </ul>	<b>Accompanying Materials</b> <ul style="list-style-type: none"> <li>• Pathologist-marked H&amp;E slide identifying area(s) of interest</li> <li>• Patient pathology report</li> </ul> <p><b>NOTE:</b> The specimen slide(s) for testing should be within 10 serial sections of the provide H&amp;E slide to ensure the presence of the lesional area of interest.</p>

### REASON FOR TESTING (required, failure to include diagnosis may delay testing)

Diagnosis:  
 ICD10 Code(s):

### TESTING REQUESTED (check all that apply)

<b>ERBB2 (PathVysion/HER2)</b> <input type="checkbox"/> Breast cancer <input type="checkbox"/> Gastric <input type="checkbox"/> Endometrial <small>Strict adherence to ASCO guidelines for min/max fixation times and type is required for HER2 testing</small> <b>Hematologic Malignancies</b> <input type="checkbox"/> C-MYC Break apart 8q24 <input type="checkbox"/> t(14;18) - IGH::BCL2 14q32/18q21 <input type="checkbox"/> BCL6 Break apart 3q27 <input type="checkbox"/> t(11;14) - IGH::CCND1 14q32/11q13 <input type="checkbox"/> t(9;22) - BCR::ABL 22q11.2/9q34 <input type="checkbox"/> t(11;18) - BIRC3::MALT1 11q22/18q21 <input type="checkbox"/> KMT2A (MLL) Break apart 11q23 <input type="checkbox"/> IgH Break apart 14q32 <input type="checkbox"/> ALK Break apart 2p23 <input type="checkbox"/> ATM/CEP11 11q22.3 <input type="checkbox"/> DI3S319/LAMP1 13q14.2/13q14 <input type="checkbox"/> TP53/CEP17 17p13.1	<b>Sarcomas</b> <input type="checkbox"/> DDIT3 Break apart (CHOP) 12q13 <input type="checkbox"/> FOXO1 Break apart (FKHR) 13q14 <input type="checkbox"/> FUS Break apart 16p11 <input type="checkbox"/> SS18 Break apart 18q11.2 <input type="checkbox"/> EWSR1 Break apart 22q12 <input type="checkbox"/> MDM2 Amplification 12q15/12cen <b>Lung Cancer</b> <input type="checkbox"/> ALK Rearrangement (IVD) for NSCLC 2p23.3 <input type="checkbox"/> ROS1 Break apart 6q22 <input type="checkbox"/> RET Break apart 10q11 <input type="checkbox"/> MET Amplification 7q31.2/7cen <b>Neuropathologic Malignancies</b> <input type="checkbox"/> 1p36 Deletion 1p36/1q25 <input type="checkbox"/> 19q13 Deletion 19p13/19q13 <input type="checkbox"/> EGFR Amplification 7p12/cen <input type="checkbox"/> Loss of 10q (PTEN) 10q23/10cen <input type="checkbox"/> Loss of 14q 14q32 <input type="checkbox"/> Loss of 22q 22q12	<input type="checkbox"/> Loss of CDKN2A (p16) 9p21/9cen <input type="checkbox"/> N-MYC Amplification 2p24.1/2cen <input type="checkbox"/> C-MYC Amplification 8q24.12-q24.13/8cen <input type="checkbox"/> BRAF::KIAA1549 7q34 <input type="checkbox"/> 17q gain 7q11.2-q12/17cen <b>Other</b> <input type="checkbox"/> USP6 Break Apart 17p13.2 <input type="checkbox"/> MAML2 Break Apart 11q21
--	---	--

**ADDITIONAL NOTES:**

**Healthcare Professional Signature to Authorize Testing and Statement of Medical Necessity**  
 I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT INFORMATION**

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):
------------	-------------	-----	-------------------

**BILLING INFORMATION  
(CHECK ONE)**
 **Bill Patient/Insurance-Complete Section A**
 **Bill Submitting Institution-Complete Section B**
**SECTION A-PATIENT/INSURANCE BILLING INFORMATION**

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. For MEDICAID patients, Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered services. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at (314) 362-5641 or via email at [path-billing@email.wustl.edu](mailto:path-billing@email.wustl.edu) for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):
CPT Codes and Unit Authorized:	

**ATTACH COPY OF INSURANCE CARD (if not available, complete the following)**

Policy Holder's Name			Insurance Co. Name:	
Last:	First:	MI:	Insurance Co. Phone:	
Policy Holder's Date of Birth (mm/dd/yyyy):			Plan Name:	
Relationship to Patient:			ID#:	Group#:

**SECTION B-INSTITUTIONAL BILLING**

Institution Name:				
Contact Name:			PO Number (if applicable):	
Email:				
Accounts Payable Billing Address:				
City:		State:		ZIP:
Phone:		Fax:		