

Ship samples to:

Washington University Pathology Services
 Attention: AMP Core Lab
 509 S. Euclid Ave. | MSC, 8024-14-04
 St. Louis, MO 63110
 Tel: (314) 747-1100 | Fax: (314) 362-4080

Office use only

Date/Time Received:
 Accession Number:
 Technician Initial:
 Received:

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

PATIENT IDENTIFICATION				PHYSICIAN ORDERING TEST <i>(NPI required)</i>			
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:	
<input type="checkbox"/> E Indian		<input type="checkbox"/> Hispanic		<input type="checkbox"/> Jewish-Ashkenazi		<input type="checkbox"/> Jewish-Sephardic	
<input type="checkbox"/> Mediterranean		<input type="checkbox"/> Native Hawaiian/Pacific Islander		<input type="checkbox"/> Other		Email:	
				Notes:			

SPECIMEN INFORMATION	
Date of biopsy:	Outside case number:
Other notes:	

REASON FOR TESTING <i>(required)</i>
Diagnosis:
ICD10 Code(s):

TESTING REQUESTED <i>(check all that apply)</i>						
<input type="checkbox"/> H & E Stain	<input type="checkbox"/> PAS w/Diastase	<input type="checkbox"/> Calretinin	<input type="checkbox"/> CD57	<input type="checkbox"/> D2-40 Podoplanin	<input type="checkbox"/> Mammaglobin	<input type="checkbox"/> PR
Special Stains	<input type="checkbox"/> Reticulin, Gomori's	<input type="checkbox"/> CD10	<input type="checkbox"/> CD61	<input type="checkbox"/> Desmin	<input type="checkbox"/> Melan-A (Red)	<input type="checkbox"/> PSAP
<input type="checkbox"/> AFB	<input type="checkbox"/> Thioflavin S	<input type="checkbox"/> CD138	<input type="checkbox"/> CD68	<input type="checkbox"/> E-cadherin	<input type="checkbox"/> MLH-1	<input type="checkbox"/> pTDP-43
<input type="checkbox"/> Alcian Blue 2.5	<input type="checkbox"/> Trichrome	<input type="checkbox"/> CD15	<input type="checkbox"/> CD68 Red	<input type="checkbox"/> EMA	<input type="checkbox"/> MPX	<input type="checkbox"/> RCC
<input type="checkbox"/> Alcian Blue/PAS	<input type="checkbox"/> Von Kossa - Calcium	<input type="checkbox"/> CD163	<input type="checkbox"/> CD7	<input type="checkbox"/> ER	<input type="checkbox"/> MSH-2	<input type="checkbox"/> S-100
<input type="checkbox"/> Bielschowsky	Antibodies	<input type="checkbox"/> CD1a	<input type="checkbox"/> CD79a	<input type="checkbox"/> GATA 3	<input type="checkbox"/> MSH-6	<input type="checkbox"/> SMA
<input type="checkbox"/> Bile	<input type="checkbox"/> a-Synuclein	<input type="checkbox"/> CD2	<input type="checkbox"/> CD8	<input type="checkbox"/> GCDFP-15	<input type="checkbox"/> MUM1	<input type="checkbox"/> SMMS-1
<input type="checkbox"/> Colloidal Iron	<input type="checkbox"/> a-Synuclein Red	<input type="checkbox"/> CD20	<input type="checkbox"/> CD99	<input type="checkbox"/> GFAP	<input type="checkbox"/> Myogenin	<input type="checkbox"/> SV40
<input type="checkbox"/> Copper	<input type="checkbox"/> ALK-1	<input type="checkbox"/> CD21	<input type="checkbox"/> CDX-2	<input type="checkbox"/> Glycophorin A	<input type="checkbox"/> Napsin A	<input type="checkbox"/> Synaptophysin
<input type="checkbox"/> Elastic (VVG)	<input type="checkbox"/> AR	<input type="checkbox"/> CD23	<input type="checkbox"/> Chromogranin A	<input type="checkbox"/> Glypican-3	<input type="checkbox"/> Neurofilament	<input type="checkbox"/> TdT
<input type="checkbox"/> Fite	<input type="checkbox"/> BCL-2	<input type="checkbox"/> CD3	<input type="checkbox"/> CK-Cam 5.2	<input type="checkbox"/> Granzyme B	<input type="checkbox"/> Oct-4	<input type="checkbox"/> TRPS1
<input type="checkbox"/> Fontana-Masson	<input type="checkbox"/> BCL-6	<input type="checkbox"/> CD30	<input type="checkbox"/> CK-HMW	<input type="checkbox"/> HePar-1	<input type="checkbox"/> P16 INK4a	<input type="checkbox"/> TTF-1
<input type="checkbox"/> GMS	<input type="checkbox"/> Beta-amyloid	<input type="checkbox"/> CD31	<input type="checkbox"/> CK-pan	<input type="checkbox"/> Her2	<input type="checkbox"/> P40	<input type="checkbox"/> Vimentin
<input type="checkbox"/> Iron Stain	<input type="checkbox"/> Beta-catenin	<input type="checkbox"/> CD34	<input type="checkbox"/> CK 19	<input type="checkbox"/> HMB-45	<input type="checkbox"/> P53	<input type="checkbox"/> WT-1
<input type="checkbox"/> Jones' Silver	<input type="checkbox"/> C4d	<input type="checkbox"/> CD4	<input type="checkbox"/> CK 20	<input type="checkbox"/> HMB-45 Red	<input type="checkbox"/> P63	ISH Probes
<input type="checkbox"/> LFB/PAS	<input type="checkbox"/> C-Kit	<input type="checkbox"/> CD43	<input type="checkbox"/> CK 5/6	<input type="checkbox"/> IgG4	<input type="checkbox"/> PAX-5	<input type="checkbox"/> EBER
<input type="checkbox"/> Melanin Bleach	<input type="checkbox"/> C-MYC	<input type="checkbox"/> CD45	<input type="checkbox"/> CK 7	<input type="checkbox"/> INI-1	<input type="checkbox"/> PAX-8	<input type="checkbox"/> Kappa light chain
<input type="checkbox"/> Mucicarmine	<input type="checkbox"/> CA 19-9	<input type="checkbox"/> CD5	<input type="checkbox"/> CK 8/18	<input type="checkbox"/> Ki-67	<input type="checkbox"/> PHF-Tau	<input type="checkbox"/> Lambda light chain
<input type="checkbox"/> PAS	<input type="checkbox"/> CA125	<input type="checkbox"/> CD56	<input type="checkbox"/> Cyclin D1	<input type="checkbox"/> Lysozyme	<input type="checkbox"/> PMS-2	<input type="checkbox"/> HPV High Risk (HR)

Block ID	Tissue Type	Block ID	Tissue Type

ADDITIONAL COMMENTS:

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):
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**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 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:		