

Sample shipping address:

Washington University Department of Pathology & Immunology
 Clinical Support Office
 425 S. Euclid Ave. | MSC 8024-14-4711 | St. Louis MO 63110
 Tel: (314) 747-7337 | Fax: (314) 747-7336

Sample drop-off locations:

Children's Hospital One Children's Place Central Receiving 2N-25 St. Louis, MO 63110 Tel: (314) 454-4161	North Campus Lab Institute of Health (IOH) Core Lab 425 S. Euclid Ave. Room 4701 St. Louis, MO 63110 Tel: (314) 362-1470
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This requisition has two pages, please complete both pages to ensure testing.

PATIENT IDENTIFICATION
PHYSICIAN ORDERING TEST (NPI required)

Patient Status: Inpatient Outpatient Office Visit

Name Last: _____ First: _____ MI: _____

DOB (mm/dd/yyyy): _____ Sex: Male Female

Medical Record # (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Ethnicity (select all that apply)

African American Asian Caucasian/NW European

E Indian Hispanic Jewish-Ashkenazi Jewish-Sephardic

Mediterranean Native Hawaiian/Pacific Islander Other

Name: _____

Institution: _____

NPI: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Alternative Contact Information:

Phone: _____ Email: _____

Notes: _____

SPECIMEN TYPE

Fresh Tissue

Formalin-Fixed Paraffin-Embedded Tissue Block

Buccal Swab (Please call the laboratory before sending)

*Peripheral Blood (Please call the laboratory before sending)

Other: _____

*Please note: Sanger sequencing on peripheral blood will be performed free of charge for variants identified in the primary specimen with an allelic fraction between 30-40% to further evaluate variant origin. Sanger sequencing may be performed at an additional charge for all other variants at the request of the ordering clinician

Pathology Case Number (if applicable): _____

Date Collected: _____

Time Collected: _____

Collected by: _____

Sample Source: _____

REASON FOR TESTING (Required-failure to include diagnosis may delay testing)

Diagnosis: _____

ICD10 Code(s): _____

TESTING REQUESTED All tests include next-generation sequencing of the coding exons of listed genes to detect single nucleotide variants and small insertions and deletions. *Clinicians ordering PIK3CA only or a custom panel will have the option to order a focused or comprehensive panel. A comprehensive order will allow the laboratory to reflex to a 75 gene panel at no additional charge. This reflex will only be available for PIK3CA and certain custom orders. Please find complete gene lists at pathologyservices.wustl.edu.

<input type="checkbox"/> Somatic Overgrowth panel with interpretation (49 genes)	<input type="checkbox"/> Somatic Undergrowth panel with interpretation (6 genes)
<input type="checkbox"/> Vascular Anomalies panel with interpretation (65 genes)	<input type="checkbox"/> Maffucci Syndrome panel with interpretation (2 genes)
<input type="checkbox"/> Nevus panel with interpretation (28 genes)	<input type="checkbox"/> McCune Albright panel with interpretation (5 genes)
<input type="checkbox"/> Rasopathies panel with interpretation (26 genes)	PIK3CA-Related Overgrowth Spectrum panel with interpretation
<input type="checkbox"/> Cortical Malformations and Epilepsy panel with interpretation (39 genes)	<input type="checkbox"/> Focused (1 gene) <input type="checkbox"/> Comprehensive (75 genes)
<input type="checkbox"/> Inborn Errors of Immunity panel with interpretation (9 genes)	Custom Panel Order with interpretation
	<input type="checkbox"/> Focused (genes specified in additional notes section below) <input type="checkbox"/> Comprehensive (75 genes)

Targeted testing for known gene variant

Gene: _____ Variant: _____

Please include copy of proband report Lab that performed testing: _____ Relationship to patient above: _____

ADDITIONAL NOTES:

Healthcare Professional Signature to Authorize Testing, Statement of Medical Necessity and Transmission of Results Verification

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.

The undersigned Client authorizes the Washington University School of Medicine to send Protected Healthcare Information (PHI) as identified in the Health Insurance Portability and Accountability Act (HIPAA) to the facsimile phone number above. Client acknowledges they are solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location and use of the facsimile machine complies with all applicable HIPAA regulations.

Signature: _____ Date: _____

Below, office use only:

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

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:	