

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: <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 <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				Phone:		Email:	
				Notes:			

SPECIMEN TYPE		
<input type="checkbox"/> Testing from Archival Specimen(s) (prior biopsies)	<input type="checkbox"/> Previous Pathology Case Number: <small>For samples located outside of BJH submit: (1) Signed Patient Release for Surgical Material Form & (2) Pathology Report</small>	<input type="checkbox"/> New Specimen(s)

PRIMARY SAMPLE TYPE (required to select one)			
<input type="checkbox"/> Formalin-fixed paraffin embedded tissue	<input type="checkbox"/> Fresh Tissue (culture/transport media)	Date Collected (mm/dd/yyyy):	
<input type="checkbox"/> Buccal Swab (contact us before sending)	<input type="checkbox"/> Other:	Collected By:	Sample Source:
SECONDARY SAMPLE TYPE			
<input type="checkbox"/> Peripheral Blood (recommended in addition to primary sample for comparative analysis)	<input type="checkbox"/> Other	Date Collected (mm/dd/yyyy):	
		Collected By:	

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. Focused analysis includes the genes in the focused panel only. Comprehensive analysis is performed in two stages: 1) initial analysis of the focused subset only. Identification of clinically significant (pathogenic or likely pathogenic) variants precludes further analysis and a final report is issued; 2) if no pathogenic/likely pathogenic variants are identified in the focused panel, additional genes from the larger Mosaicism Disorders Gene Panel are analyzed and variants from these genes are reviewed and classified. For all reported variants, evidence for an association with the patient's indicated phenotype is documented in the variant interpretation section for any reported variant.

Please see website (gps.wustl.edu) for gene lists and details on the ordering of focused versus comprehensive gene panels.

Somatic Overgrowth Panel with interpretation <input type="checkbox"/> Focused 25 genes <input type="checkbox"/> Comprehensive 37 genes	PIK3CA-Related Overgrowth Spectrum Disorders with interpretation <input type="checkbox"/> Focused 1 gene <input type="checkbox"/> Comprehensive 37 genes
Rasopathies Panel with interpretation <input type="checkbox"/> Focused 14 genes <input type="checkbox"/> Comprehensive 37 genes	McCune Albright Syndrome with interpretation <input type="checkbox"/> Focused 1 gene <input type="checkbox"/> Comprehensive 37 genes
Nevus Panel with interpretation <input type="checkbox"/> Focused 12 genes <input type="checkbox"/> Comprehensive 37 genes	Curry-Jones Syndrome with interpretation <input type="checkbox"/> Focused 1 gene <input type="checkbox"/> Comprehensive 37 genes
Maffucci Syndrome Panel with interpretation <input type="checkbox"/> Focused 2 genes <input type="checkbox"/> Comprehensive 37 genes	Custom Panel with interpretation (Please indicate custom request in the additional notes section below) <input type="checkbox"/> Focused-only custom genes listed below <input type="checkbox"/> Comprehensive 37 genes
<input type="checkbox"/> Targeted testing for known familial gene variant	Gene: _____ Variant: _____ Relationship to patient above: _____

Please include copy of proband report

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:
<i>Below, office use only:</i>	
Date/Time Received:	Accession Number:
	Technician Initial:

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):
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INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. 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 Units Authorized:	

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

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

SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our Patient Accounts Manager office at (314) 362-5641 or via email at path-billing@email.wustl.edu.

.....Reference Laboratories: complete section below.....

INSTITUTIONAL BILLING

Institution Name:		
Contact Name:		
Email:		
Billing Address:		
City:	State:	Zip:
Phone:	Fax:	