1. **Clinician: Complete patient information at top and test requested. Please be aware that some tests are triaged.**
2. **Pre-authorization with insurance company before requesting test.**
3. **Deliver, e-mail or Fax to Pathology 859-323-2094.**

PATIENT INFORMATION *(Completed by clinician)*

PATIENT NAME: _____ LOCATION (ex. Markey): _____

MRN: _____ DOB: _____ ATTENDING: _____ PAGER/PHONE: _____

Reason for ordering test: _____

TEST REQUESTED – IN-HOUSE

IMHC LAB
- ____HER2 IMHC (60461, 60462)
- ____ALK IMHC (60461, 60462)
- ____ MMR by IHC (60461, 60462)
- ____ HER2CISH (60461, 60462)

IMP LAB
- ____ BRAF MUTATION (81210)
- ____ KRAS MUTATION (81275)
- ____ IDH1/IDH2 (81403)

FISH LAB
- ____ HER2/NEU FISH (88368)
- ____ 1P19Q FISH (88368)
- ____ ALK FISH (88368)
- ____ EGFR FISH (88368)
- ____ EWS FISH (88368)
- ____ SYT FISH (88368)
- ____ MDM2 FISH (88368)
- ____ c-MYC FISH (88368)