



# Clinical Molecular and Genomic Pathology

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## Solid Tumor Test Requisition Form

### Patient Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
MR#: \_\_\_\_\_  
DOB (MM/DD/YYYY): \_\_\_\_\_  
Gender:  Male  Female

### Clinical Information

Tissue Source (Required): \_\_\_\_\_  
Clinical Diagnosis (Required): \_\_\_\_\_

### Sample Information

Tissue Block(s) \_\_\_\_\_  
Collection Date: \_\_\_\_\_  
Collector: \_\_\_\_\_

### Test Requested

Comprehensive Solid Tumor Panel (198 Genes)

### Block Return Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Referring Physician

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_  
Requesting Physician/Genetic Counselor/Other Contact Name:  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Referring Physician Signature (Required):  
\_\_\_\_\_

### Billing Information

Medicaid/Medicare  
 Commercial Insurance  
Pre-Authorization (Required): \_\_\_\_\_  
 Patient Responsibility

#### Note:

- > Provide all billing related information.
- > For commercial insurance, preapproval required. Test will not be performed until preapproval is obtained.
- > For Medicaid/Medicare, medical necessity MUST be provided.

### Official Use Only

Received by: \_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Block Returned Date: \_\_\_\_\_ Tracking: \_\_\_\_\_