

A PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

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

SSN: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

B ORDERING PHYSICIAN INFORMATION

Physician: _____

NPI #: _____

Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Office Contact: _____

SIGNATURE OF ORDERING PHYSICIAN: _____ **DATE:** _____

To be medically necessary, diagnostic laboratory tests must be ordered by a treating physician who provides a consultation or treats a patient for a specific medical problem and who uses the findings in the management of the patient. If the ordering physician is not the treating physician, the ordering physician confirms by signing this form that the treating physician has ordered the Pathwork Tissue of Origin Test.

C PATHOLOGIST INFORMATION

Pathologist: _____

Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

D SPECIMEN INFORMATION—please attach pathology report

Biopsy site: _____

Date of surgery/specimen collection: _____

Date of discharge (or date of outpatient encounter): _____

Date of specimen removal from storage: _____

Specimen type (check as appropriate):

Formalin fixed, paraffin embedded block

Number of blocks: _____ Specimen ID #: _____ Block #: _____

Unstained slides from FFPE block (See Specimen Requirements on back of form)

Number of unstained slides: _____ Number of H&E slides: _____ ID #: _____

In an effort to obtain a test result, may Pathwork micro-dissect tumor tissue directly from the block?

Yes No Initials: _____

FOR INTERNAL USE ONLY:

Date: _____

Initials: _____

AFFIX PWDL LABEL

E TESTS REQUESTED

Tissue of Origin Test

Tissue of Origin Endometrial Test (if indicated)*

Tissue of Origin Head & Neck Test (if indicated)**

Mutation testing (if indicated by the Tissue of Origin Test result)
Please specify mutation test below.

Mutation test only—no Tissue of Origin Test. Please specify mutation test below.

Mutation test by RT-PCR—please specify:

EGFR Reflex to KRAS (if EGFR is negative)

KRAS Reflex to BRAF (if KRAS is negative)

BRAF ICD-9 Code for mutation test(s): _____

* If the Tissue of Origin Test results in a top Similarity Score of Ovarian, Pathwork Diagnostics Laboratory may run the Tissue of Origin Endometrial Test, if ordered.

** If the Tissue of Origin Test results in a top Similarity Score of Non-small Cell Lung Cancer, Pathwork Diagnostics Laboratory may run the Tissue of Origin Head & Neck Test, if ordered.

F BILLING AND INSURANCE INFORMATION

ICD-9 CODE FOR TISSUE OF ORIGIN

Please check the ICD-9 code that corresponds to the patient's diagnosis. A list of ICD-9 codes is provided below for the convenience of the ordering physician. Physicians are not required to use these codes but should report the ICD-9 code that best describes the reason for performing the test. Please complete "OTHER" if the correct code is not listed here.

<p>SECONDARY AND UNSPECIFIED MALIGNANT NEOPLASM OF:</p> <p><input type="checkbox"/> 196.0 lymph nodes of head, face & neck</p> <p><input type="checkbox"/> 196.1 intrathoracic lymph nodes</p> <p><input type="checkbox"/> 196.2 intra-abdominal lymph nodes</p> <p><input type="checkbox"/> 196.3 lymph nodes of axilla & upper limb</p> <p><input type="checkbox"/> 196.5 lymph nodes of inguinal region and lower limbs</p> <p><input type="checkbox"/> 196.6 intrapelvic lymph nodes</p> <p><input type="checkbox"/> 196.8 lymph nodes of multiple sites</p> <p><input type="checkbox"/> 196.9 lymph nodes site unspecified</p>	<p>NEOPLASMS OF UNSPECIFIED NATURE:</p> <p><input type="checkbox"/> 239.0 digestive system</p> <p><input type="checkbox"/> 239.1 respiratory system</p> <p><input type="checkbox"/> 239.2 bone soft tissue & skin</p> <p><input type="checkbox"/> 239.3 breast</p> <p><input type="checkbox"/> 239.4 bladder</p> <p><input type="checkbox"/> 239.5 other genitourinary organs</p> <p><input type="checkbox"/> 239.6 brain</p> <p><input type="checkbox"/> 239.7 endocrine glands & other parts of nervous system</p> <p><input type="checkbox"/> 239.81 retina & choroid</p> <p><input type="checkbox"/> 239.89 other specified sites</p> <p><input type="checkbox"/> 239.9 site unspecified</p>
<p>MALIGNANT NEOPLASM WITHOUT SPECIFICATION OF SITE:</p> <p><input type="checkbox"/> 199.0 disseminated malignant neoplasm</p> <p><input type="checkbox"/> 199.1 other malignant neoplasm of unspecified site</p> <p><input type="checkbox"/> 199.2 associated with transplant organ</p>	
<p><input type="checkbox"/> OTHER</p>	

BILLING INFORMATION

<p>BILL THE FOLLOWING:</p> <p><input type="checkbox"/> Private insurance</p> <p><input type="checkbox"/> Medicaid</p> <p><input type="checkbox"/> Sending facility</p> <p><input type="checkbox"/> Patient self-pay (Contact Customer Care)</p> <p><input type="checkbox"/> Medicare (Complete right)*</p>	<p>FOR MEDICARE PATIENTS—AT THE TIME OF SPECIMEN COLLECTION:</p> <p><input type="checkbox"/> Hospital inpatient</p> <p><input type="checkbox"/> Hospital outpatient</p> <p><input type="checkbox"/> Non-hospital outpatient</p>
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* Medicare specimens ordered at least 14 days after patient discharge will be billed directly to Medicare. Otherwise, Pathwork Diagnostics is required to bill the sending facility.

INSURANCE INFORMATION

Attach copy of front & back of patient ins. card & face sheet, or complete:

Member ID #: _____

Relationship to insured: Self Spouse Dependent Other

Name of insured—Last: _____ First: _____

Primary carrier: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

To bill secondary ins., attach a copy of front & back of the secondary ins. card.

Pathwork Diagnostics Laboratory
 595 Penobscot Drive Redwood City, CA 94063
 1.877.808.0006 ■ 1.650.366.1003 ■ Fax: 1.650.599.9501
www.pathworkdx.com

Test Requisition Form Instructions & Specimen Requirements

Complete a Test Requisition Form for each specimen, using a black or blue ballpoint pen. Please print.

A PATIENT INFORMATION

Complete all lines. Some lines require more than one piece of information.

B ORDERING PHYSICIAN INFORMATION

1. Enter physician's name and NPI number.
2. Enter physician's facility, complete address, phone number and fax number.
3. Enter physician's email address.
4. **Physician must sign the test requisition form. Print the physician's name and date clearly.**

C PATHOLOGIST INFORMATION

1. Enter submitting pathologist's name.
2. Enter submitting pathologist's facility, complete address, phone number and fax number.
3. Enter submitting pathologist's email address.

D SPECIMEN INFORMATION

1. **Attach a pathology report.**
2. Include the biopsy site.
3. Indicate the date of surgery/specimen collection and the date of patient discharge (or outpatient encounter).
4. Indicate the date of specimen removal from storage.
5. Indicate the sending hospital/facility.

SPECIMEN TYPE:

1. The preferred specimen type is a paraffin block. Enter the number of paraffin blocks and the corresponding path ID number and block ID number(s).
2. If sending unstained slides from a paraffin block, enter the number of unstained slides, the number of H&E slides that you are sending, and the ID number.
3. Indicate whether or not Pathwork Diagnostics has permission to micro-dissect the block if necessary, and initial.

E TESTS REQUIRED

1. Select desired test (Tissue of Origin Test or Mutation Test only – no Tissue of Origin Test).
2. When selecting Tissue of Origin Test, please check boxes below for additional test requests, depending upon outcome of Tissue of Origin Test. There are 3 choices:
 - a. Tissue of Origin Endometrial Test.
 - b. Tissue of Origin Head & Neck Test.
 - c. Automatically perform mutation testing if indicated by the Tissue of Origin Test result.
3. If selecting "Automatically perform mutation testing if indicated by the Tissue of Origin Test result" please check box(es) to indicate selected mutation tests(s).
4. If selecting "Mutation Test only—no Tissue of Origin Test", please check box(es) to indicate selected mutation tests(s), and provide ICD-9 code.

F BILLING AND INSURANCE INFORMATION

ICD-9 CODE FOR TISSUE OF ORIGIN:

1. Check the ICD-9 code that corresponds to the patient's diagnosis.
2. If there is no ICD-9 code listed that corresponds to the patient's diagnosis, check the Other box and supply the ICD-9 code in the space.

BILLING INFORMATION:

1. Under BILL THE FOLLOWING, select the payer.
2. If you select Patient self-pay, please contact Pathwork Customer Care.
3. If you select Medicare, select the patient status at time of specimen collection, to the right.

INSURANCE INFORMATION:

1. Attach a copy of the front & back of the patient's insurance card and a face sheet, if available.
2. If the patient's insurance card is not available, complete all lines.
3. To bill secondary insurance, attach a copy of the front & back of the secondary insurance card.

! SPECIMEN REQUIREMENTS

FFPE BLOCK:

Send a block containing at least 1 mm² of TUMOR tissue by area. Include an H&E stained slide if possible.

OR

UNSTAINED SLIDES (USS):

Send unstained slides of at least 5 µm-thickness (10 µm-thickness preferred) that contain no less than 1 mm² of TUMOR tissue.

- For tumor areas < 5 mm²—send at least 8 USS.
- For tumor areas ≥ 5 mm²—send at least 5 USS.

ACCEPTABLE SPECIMEN TYPES:

1. FFPE block of solid tissue.
2. FFPE cell buttons from fine needle aspirates (FNA), including bone marrow aspirates.
3. FFPE cell buttons from malignant effusions.
4. FFPE core needle biopsies.
5. Unstained slides from any of the above.

UNACCEPTABLE SPECIMEN TYPES:

1. Tissue that has been decalcified.
2. Any unfixed tissues or fluids.
3. Wet or frozen tissue.
4. FFPE tissue that has been previously frozen and allowed to thaw before fixation.
5. Tissue pre-embedded in agar.
6. Blood or urine.

FOR ALL SPECIMEN TYPES, PLEASE ENSURE THAT:

1. Tissue does not sit on bench for more than 1 hour before fixation.
2. Tissue is fixed in phosphate buffered formalin for between 6 and 24 hours.



ATTENTION!

Specimen processing cannot proceed without:

1. Signature of ordering physician.
2. Positive identification between the specimen and the requisition form.
3. Billing information.

Please contact Customer Care for information regarding financial aid for the patient.