

### 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:

<p><b>Children's Hospital</b>                  One Children's Place                  Central Receiving 2N-25                  St. Louis, MO 63110                  Tel: (314) 454-4161</p>	<p><b>North Campus Lab</b>                  Institute of Health (IOH) Core Lab                  425 S. Euclid Ave.   Room 4701                  St. Louis, MO 63110                  Tel: (314) 362-1470</p>
--	--

**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): <input type="checkbox"/> Testing from New Specimen(s)	<b>Previous Pathology Case Number:</b> <i>For samples located outside of BJH submit: (1) Signed Patient Release for Surgical Material Form and (2) Pathology Report</i>
Date Collected (mm/dd/yyyy):                      Time:	Collected by:
Sample Type (select one) <input type="checkbox"/> Formalin-fixed paraffin embedded tissue <input type="checkbox"/> Bone Core <input type="checkbox"/> Bone Marrow Aspirate <input type="checkbox"/> Bone Core <input type="checkbox"/> Peripheral Blood <input type="checkbox"/> Other	

REASON FOR TESTING (Required-failure to include diagnosis may delay testing)
Diagnosis:
ICD10 Code(s):

TESTING REQUESTED
In case of limited tissue, please check which type of testing should be prioritized <input type="checkbox"/> Sequencing <input type="checkbox"/> FFPE FISH

**PART 1: Next-generation sequencing.** All tests include next-generation sequencing of all coding exons of listed genes to detect single nucleotide variants and small insertions and deletions. Number of genes indicated in parentheses. For the list of genes, visit [gps.wustl.edu](http://gps.wustl.edu)

<input type="checkbox"/> Solid Tumors with interpretation (122)	<input type="checkbox"/> Breast Tumors with interpretation (42)	<input type="checkbox"/> Genitourinary Tumors with interpretation (44)
<input type="checkbox"/> Head and Neck Tumors with interpretation (41)	<input type="checkbox"/> Thoracic Tumors with interpretation(36)	<input type="checkbox"/> Hematopoietic Disorders with interpretation (54)
<input type="checkbox"/> CNS Tumors with interpretation (48)	<input type="checkbox"/> Gynecologic Tumors with interpretation (50)	<input type="checkbox"/> Melanoma with interpretation (38)

**PART 2: Select FFPE FISH testing.**

<input type="checkbox"/> ALK - 2p23 Rea.	<input type="checkbox"/> BCL6 - 3q27 Rea.	<input type="checkbox"/> BRAF - 7q34 Dup.	<input type="checkbox"/> CDKN2A - 9p21 Loss	<input type="checkbox"/> EGFR - 7p12 Amp.
<input type="checkbox"/> FGFR1 - 8p12 Amp.	<input type="checkbox"/> HER2-NEU - Amp.	<input type="checkbox"/> IGH - 14q32 Rea.	<input type="checkbox"/> KMT2A (MLL) - 11q23 Rea.	<input type="checkbox"/> MET - 7q31.2 Amp.
<input type="checkbox"/> MYC - 8q24 Amp.	<input type="checkbox"/> MYC - 8q24 Rea.	<input type="checkbox"/> MYCN - 2p24.3 Amp.	<input type="checkbox"/> PTEN - 10q23 Loss	<input type="checkbox"/> RET - 10q11.21 Rea.
<input type="checkbox"/> ROS1 - 6q22.1 Rea.	<input type="checkbox"/> 1p36/19q13 Del.	<input type="checkbox"/> 22q Loss	<input type="checkbox"/> 1p36/1q25 & IGH (14q) - 1p/14q Loss	
<input type="checkbox"/> Other:				

**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):
------------	-------------	-----	-------------------

### 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](mailto: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:	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#:

### 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](mailto:path-billing@email.wustl.edu).

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

### INSTITUTIONAL BILLING

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