Clinical Molecular and Genomic Pathology

Website: http://ukhealthcare.uky.edu/genomics/
Phone: 859-323-5327 Fax: 859-257-0029
Email: cmgp@uky.edu
Shipping Address: 800 Rose Street, HA619
Lexington, KY 40536-0293

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:

____

____

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Referring Physician

Name: ____

Address: ____

____

____

Phone: ______________________ Fax: ________________________

Email: ____

Requesting Physician/Genetic Counselor/Other Contact Name:

____

Phone: ______________________ Email: ______________________

Referring Physician Signature (Required):

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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: ____

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Block Returned Date: ___________ Tracking: __________________