REQUISITION FORM
UCSF Applied Genomics Clinical Laboratory
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PLEASE SEND EMAIL NOTIFICATION WHEN FAXING A REQUISITION FOR TESTING.

Ordering date: _____________ ICD-9 (required): 1.__________ 2.__________
Clinical Information:________________________________________________________

Pathology case #: ______________ Tissue type: _____________________ Collection date:_______
Ordering provider: ___________________ UCSF provider number: _____________________
Phone # and/or pager: ___________________ Email: ____________________________
Fax #: ___________________ Address/Box #: ____________________________
Address (cont.): __________________________________________________________________
If outside of UCSF: Institution name: ___________________ Dept: _______________
Billing address (if different): __________________________________________________________________
Billing address (cont.): __________________________________________________________________
Billing contact: _____________________ Telephone: ____________________________
Provider signature: _____________________ Date: ______________________

Test Menu
Interpretation of each test by a laboratory physician will automatically be performed and billed for.
☐ BRAF (V600)
☐ EGFR (ex19 deletion; ex20 insertion, mutation S768I/T790M; ex21 mutation L858R/L861Q)
☐ KRAS (codon 12/13)
☐ Microsatellite Instability MSI
☐ Hydatidiform Mole Genotyping

FOR LABORATORY USE ONLY

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<th>Path case #</th>
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If sending outside pathology materials, we require:
1) 5 unstained slides, cut at 10 microns on uncharged slides (6 slides at 8 microns also acceptable).
2) An adjacent H&E stained slide.
3) A copy of the pathology report.
4) PLEASE SHIP MONDAY-THURSDAY ONLY.

LBM.FRM-002 Version: 6 Effective Date: 11/25/13