REQUISITION FORM

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PLEASE SEND EMAIL NOTIFICATION WHEN FAXING A REQUISITION FOR TESTING.

Patient Name:_____

MRN#:_____

DOB (MM/DD/YY):_____

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		
Path case #	Mol #	AGL #
_____ DNA conc:: _____ng/uL FFPE ☐ smear ☐ _____ %tumor Path Initials:_____		
_____ DNA conc:: _____ng/uL FFPE ☐ smear ☐ _____ %tumor Path Initials_____		

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.