Request Forms

Instructions for Completion of a Requisition

Laboratory Requirements For Requisition And Diagnostic Information

- Provide a completed requisition, including all patient demographics.
- Verify at each visit patient's current insurance and demographic information.
- Verify that the requisition reflects current insurance and demographic information. Indicate on the requisition if there are any changes. Example: "This is a new address."
- Indicate married name and maiden name on the requisition if there has been a recent change.
- Social Security number is very important to establish the patient's Medical Record Number and to identify the patient.
- Please provide a diagnosis to support Medical Necessity for each test order. An appropriate diagnosis would be a disease state, a sign, or a symptom. Never use "R/O" or "?" for a diagnosis. The diagnosis of "normal pregnancy" will not cover all the tests you may feel are necessary for the treatment of your patient. Example:
  - —Urine culture: Please provide a sign or a symptom that your patient is experiencing such as urinary frequency, dysuria, or pain with urination
  - —DNA testing for cystic fibrosis: Two codes are necessary. Antenatal screening (V728.8) for cystic fibrosis (V77.6), indicate if any family history. If patient is not pregnant, V77.6 is sufficient.
  - —Hepatitis C: Exposure to hepatitis C, known hepatitis C carrier (V01.7) is correct or exposure to hepatitis C with pregnancy.
- We receive many requisitions with no diagnosis. The laboratory can never assume a diagnosis. If you order a prenatal profile, we cannot assume the diagnosis is pregnancy.
- If your office uses an internal form for ordering laboratory tests, it must have an area to write in the diagnosis. This will prompt your staff to always provide the diagnosis.

Help Is Available

If you have any questions regarding the appropriate diagnosis to support Medical Necessity, please call laboratory Client Services at 781-306-6915.

HALLMARK HEALTH
CLINICAL LABORATORY SERVICES
INSTRUCTIONS FOR SEMEN COLLECTION AND SPECIMEN IDENTIFICATION

PLEASE READ **the following instructions and complete the form with the appropriate information.**

A. Abstain from intercourse or ejaculation for two days prior, but no longer than five days.
B. Urinate immediately prior to collection (do not use soap).
C. Obtain the specimen by masturbation only. No lubricants, condoms, vaginal or oral stimulation, etc. should be used.
D. Collect specimen in a sterile container, labeled with name, DOB and time of collection.
E. After collection, place the specimen container, tightly capped, in the bag provided, and return promptly to **Melrose Wakefield Hospital Laboratory**, **1st Floor Out Patient Services**.
F. It is recommended the specimen be collected at MWH Hospital. If that is not possible, please consider the following limitations:
   - Protect specimen from extreme temperatures during transport to MWH Laboratory.
   - Take precautions to maintain the temperature of the specimen between room temperature 68° F and body temperature 98.6°F.
   - Write name, DOB, date and time of collection on label.
   - **Within one hour of collection,** deliver labeled specimen container directly to **Melrose Wakefield Hospital Laboratory, 1st Floor Out Patient Services**. Please bring this form with you.

G. Semen Collection for Fertility Studies:
   - **The physician's office or the patient must call and schedule an appointment with Ancillary Support at 781-338-7111. Scheduling must receive a test order from the doctor before the patient may call to schedule an appointment. FAX 781-338-7110.**
   - Specimens are ONLY accepted Monday- Friday 8:00 a.m.-2:00p.m.
   - Within one hour of collection, deliver labeled specimen container directly to the **1st Floor, Melrose Wakefield Hospital Out Patient Services**.
   - **If you cannot keep this appointment, please call Ancillary Support at 781-338-7111 to cancel and reschedule.**

H. **Post Vasectomy specimens are accepted at any time and do not need to be scheduled.**

PLEASE COMPLETE THE FOLLOWING AND BRING THIS FORM WITH YOU

DATE:_____ Time of Collection: _____

Patient's Name: _____

Referring Physician: _____

Length of Abstinence (#of days since last ejaculation or sexual intercourse): _____

PLEASE CHECK APPROPRIATE INFORMATION IN EACH SECTION:

Collection Site Lab_____ Other _____

Transportation Problems: Yes_____ No_____ *(i.e.: exposure to extreme temperature)*

Specimen Collection:
_____Collected Entire Specimen
_____Missed First Portion of Ejaculate
_____Missed Middle Portion of Ejaculate
_____Missed Last Portion of Ejaculate

Type of Test
_____Semen Analysis for Fertility Studies
_____Semen Culture
_____Post Vasectomy

Integrated Genetics Requisition

Integrated GENETICS
LabCorp Specialty Testing Group

PREGNANCY/PRECONCEPTION TEST REQUISITION

PLEASE SUBMIT A SEPARATE REQUISITION FOR EACH PATIENT, INCLUDING TWINS

Highlighted fields are required.

Client Information / Patient Information

Name (Last / First / MI)

Address

City State Zip

☐ Male ☐ Female Date of Birth / /

Home Phone Work Phone

Social Security Number

Lab # Hospital #

I attest that this patient has been informed about and has given consent for the test(s) I have ordered below under applicable law.

Physician/Authorized Signature:

NPI#: Taxonomy#:

Referring Physician (print):

Genetic Counselor (print):

Date drawn: / / Drawn by:

Pregnant: ☐ Yes ☐ No First pregnancy ☐ Yes ☐ No Date sent: / /

Specimen Type (Check one only):

Parental ☐ Peripheral Blood ☐ Mouthwash ☐ Blood spot card

Fetal ☐ Fetal Blood ☐ Amniotic Fluid ☐ Chorionic Villi ☐ POC

Back-up culture by: ☐ Integrated Genetics ☐ Other _____ Hold for: _____

Ethnicities (Check all that apply): ☐ Caucasian ☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Asian ☐ African American ☐ Native American ☐ Hispanic ☐ Other: _____

Maternal Serum/Plasma Screening

550746	☐ informaSeq℠ Prenatal Test (10w+)*	302	☐ IntegratedScreen℠*
550757	☐ informaSeq℠ with Y Analysis (10w+)*	302	☐ Serum IntegratedScreen℠* (without NT measurement)
550716	☐ informaSeq℠ with X,Y Analysis (10w+)**	325	☐ AFP4® (15w 0d – 21w 6d)
315	☐ FirstScreen®* (10w 3d – 13w 6d)	310	☐ MSAFP (QNTD only; 15w 0d – 23w 6d)
335	☐ SequentialScreen℠*		

*Professional associations recommend use in high risk pregnancy
**singleton pregnancy
*Dried blood spot samples acceptable for first trimester only

Clinical Information for Maternal Serum/Plasma Screening

Gravida: Para: SAB: TAB: # Fetuses*: 1 ☐ 2 ☐ >2 ☐ Repeat Screen ☐

Sonographer Name: NTQR ID#:

Reading MD NTQR ID#: Practice Location ID#:

U/S date: / / GA on U/S date: wks days Maternal Weight lbs.

NT: mm CRL: mm For Twins: NT: mm CRL: mm

LMP date: / / EDC date: / / by ☐ U/S ☐ LMP ☐ PE ☐ IVF

IVF fertilization date**: / / IVF egg donor: ☐ Self ☐ Non-Self Donor Age:

Y ☐ N ☐ Patient is Rx-dependent diabetic prior to pregnancy (648.03, 250.00)

☐ insulin (V58.67) ☐ oral hypoglycemics (V58.69)

Y ☐ N ☐ Previous Down syndrome pregnancy/child (655.23)

Y ☐ N ☐ Family hx of NTD (655.23), specify: Relative (V18.9):

*Assume 1 if left blank
**Assume non IVF if left blank

Single Gene Disorders/Diseases

Ashkenazi Jewish Testing

(may be appropriate for other ethnicities)

☐ Check here for all Ashkenazi Jewish Carrier Tests or check separately

562 ☐ Bloom syndrome*
554 ☐ Canavan disease*
530 ☐ CFplus® (97 mutation test)†*
519 ☐ Dihydrolipoamide dehydrogenase deficiency*
207 ☐ Familial dysautonomia*
585 ☐ Familial hyperinsulinism*
534 ☐ Fanconi anemia (Group C)*
595 ☐ Gaucher disease*
522 ☐ Glycogen storage disease type 1a*
501 ☐ Joubert syndrome 2*
518 ☐ Maple syrup urine disease*
573 ☐ Mucolipidosis type IV*
587 ☐ Nemaline myopathy*
557 ☐ Niemann-Pick type A*
593 ☐ Tay-Sachs enzymes and DNA*
350 ☐ Tay-Sachs enzymes only
589 ☐ Usher syndrome type IF*
599 ☐ Usher syndrome type III*
502 ☐ Walker-Warburg syndrome*

Pan Ethnic Testing

☐ Check here for all Pan Ethnic Carrier Tests or check separately

530 ☐ CFplus® (97 mutation test)†*
523 ☐ Fragile X Carrier Screen (no fam hx)†
516 ☐ Spinal muscular atrophy (SMA)†* Both parents bloods required for prenatal dx
540 ☐ Inheritest® Carrier Screen†
541 ☐ Inheritest® Select Carrier Screen†

☐ Check here for all tests listed below or order individually

516 ☐ Spinal muscular atrophy (SMA)†*
523 ☐ Fragile X Carrier Screen†
350 ☐ Tay-Sachs enzymes
☐ Mutation Specific Sequencing (call before sending)

Required: Gene(s): _____

Mutation(s): _____

Other Tests‡

521 ☐ Fragile X Test (symptomatic/fam hx)*
528 ☐ Maternal cell contamination*
538 ☐ Poly (T) Testing for CFTR Intron 8
535 ☐ Sickle cell anemia* (prenatal dx only)
593 ☐ Tay-Sachs DNA (prenatal dx only)*
591 ☐ Y chromosome microdeletions

Other test: _____

Thrombophilia‡

549 ☐ Factor II (prothrombin G20210A)
548 ☐ Factor V (Leiden)
526 ☐ MTHFR (C677T)

Hereditary Breast and Ovarian Cancer

(clinical questionnaire required, components on back)

☐ BRCAssure℠: Comprehensive Analysis
☐ BRCAssure℠: Ashkenazi Jewish Panel

*Maternal cell contamination analysis required for all prenatal dx (send a maternal sample).

Cytogenetics/FISH/Biochem

100 ☐ Amniotic fluid chromosomes
300 ☐ AF-AFP†
330 ☐ Acetylcholinesterase (AChE)
110 ☐ CVS chromosomes
105 ☐ InSight® (FISH for 13, 18, 21, X, Y)
Other _____

287 ☐ DiGeorge/VCF (22q11.2 deletion)
☐ Other FISH: _____
123 ☐ Fetal blood (PUBS) chromosomes
180 ☐ POC chromosomes: GA week: _____ POC tissue type: _____
120 ☐ Blood Chromosomes (parental)

Clinical Information/Test Indications for Cytogenetics/FISH

Gravida: Para: SAB: TAB: # Fetuses: ☐ 1 ☐ 2 ☐ >2 Maternal Weight lbs.

U/S date: / / GA on U/S date: wks days LMP date: / / EDC date: / /

☐ AMA (para gravida: 659.53, multigravida: 659.63)
☐ Positive serum screen (655.83): ☐ NTD (655.03) ☐ Down syndrome (655.13) ☐ Trisomy 18 (655.13)
☐ Abnormal fetal U/S (655.83): ☐ CNS* (655.03) ☐ Other* (655.83)
☐ Family history of (655.23): ☐ NTD ☐ Chromosome abnormality* ☐ MR* ☐ Other*
☐ Parental cytogenetics following abnormal prenatal results* (F: 655.13, M: V26.39)
☐ Multiple Spontaneous abortions (SAB): ☐ F (Pregnant: 646.33, Not Pregnant: 629.81) ☐ M (V26.35)

*Provide additional information: _____

Clinical Information/Single Gene Testing (If not checked, screening assumed (V82.89))

Parental: ☐ No family history (V82.89) ☐ Abnormal fetal U/S* (655.83) ☐ Family hx: relative* (655.23) ☐ Known carrier (655.23)* ☐ Thrombophilia* (286.9) ☐ Infertility (M: 606.9, F: 628.9 ☐ Egg donor (V59.70) ☐ Sperm donor (V59.8) ☐ Congenital absence of vas deferens (752.89)

Fetal: ☐ Abnormal fetal U/S* (655.83) ☐ Family hx: relative* (655.23) ☐ Parent(s) known carrier(s)* (655.23)

*Provide additional information: _____

†Reflex policy: The following will be performed at additional charge: AChE when AF-AFP is elevated &/or GA is out of range of normative values; Fetal HGB when AF-AFP is elevated & amniotic fluid is bloody; CFTR Intron 8 poly(T) when R117H CF mutation is present; Southern blot analysis when Fragile X PCR shows >54 CGG repeats; SMN2 analysis when SMN1 indicates 0 copies.

BILLING INFORMATION

Patient Hospital Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital

Medicaid | Medicare | Insurance | Client Bill | CA XAFP | Self-Pay

☐ Billing Information Attached (Please include a copy of insurance card or face sheet.)*

*Do not attach credit card information to this form for security purposes.

Insurance Company Name _____

Policy # _____ Group # _____

Relation to Insured: | Self | Spouse | Child | Other _____

Patient Signature _____ Date: _____

INTEGRATED GENETICS INTERNAL USE ONLY

By signing this form, I hereby authorize Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to LCAH.

I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

Informed Consent/Refusal for Genetic Testing

Maternal Serum/Plasma Screening

1. The purpose of maternal serum/plasma screening is to identify pregnancies that may be at increased risk for open neural tube defects (ONTD), Down syndrome, trisomy 18, or trisomy 13.
2. The screening test I am having is (circle one):
   - Harmony™ Prenatal Test – detects >99% trisomy 21, >98% trisomy 18, 80% trisomy 13, and X,Y aneuploidy and sex determination. Accuracy of determining fetal sex is >99%; sex aneuploidies varies by condition; no information about ONTD
   - FirstScreen® – detects 83% of Down syndrome and 80% of trisomy 18; no information about ONTD
   - SequentialScreen℠ – detects 89% of ONTD, 90.4% of Down syndrome, and 90% of trisomy 18
   - IntegratedScreen℠ – detects 90% of ONTD, 92% of Down syndrome, and 90% of trisomy 18
   - Serum IntegratedScreen℠ – detects 80% of ONTD, 87% of Down syndrome, and 90% of trisomy 18
   - AFP4® – detects 80% of ONTD, 81% of Down syndrome, and 80% of trisomy 18
   - MSAFP – detects 80% of ONTD, no information about Down syndrome or trisomy 18
3. Not all affected fetuses can be detected: some will be missed by any of these screening tests.
4. Some women with normal fetuses will have abnormal screening results.
5. Abnormal screening results may indicate the need for further testing, such as ultrasound and/or CVS or amniocentesis.

DNA Testing

1. The purpose of my DNA test is to determine whether I, or my fetus if fetal testing is ordered, have mutation(s) or genetic alterations known to be associated with the following genetic condition or disease: _____
2. This testing is done on a small sample of blood; in some cases a mouthwash sample can be used. For the fetus, testing is done on amniotic fluid, CVS or fetal blood.
3. Mutations and alterations are often different in different populations. I understand that the laboratory needs accurate information about my family history and ethnic background for the most accurate interpretation of the test results.
4. When DNA testing shows a mutation or alteration, then the person is a carrier or is affected with the condition or disease tested for, or, in the case of cancer genetic testing, the person is a carrier of a mutation or alteration that may be associated with an increased risk for certain cancer(s) compared to the general population. Consulting a doctor or genetic counselor is recommended to learn the full meaning of the results and to learn if the additional testing might be necessary.
5. When the DNA testing does not show a known mutation or alteration, the chance that the person is a carrier or is affected is reduced or, in the case of cancer genetic testing, the person's risk for certain cancer(s) compared to the general population will depend on additional personal factors. There is still a chance to be a carrier or to be affected because the current testing cannot find all the possible changes within a gene.
6. In some families, DNA testing might discover non-paternity (someone who is not the real father), or some other previously unknown information about family relationships, such as adoption.

Genetic Amniocentesis

1. The purpose of amniocentesis is to detect certain birth defects, including most fetal chromosome disorders and neural tube defects.
   My reason for having amniocentesis is _____.
2. Before the amniocentesis I will have an ultrasound to help locate the placenta and fetus. Ultrasound may also detect twins, incorrect dating of the pregnancy, and some, but not all, physical defects in the fetus.
3. Amniocentesis involves inserting a needle through the woman's abdomen into the fluid in her uterus. A small amount of fluid (less than 1 ounce) is taken out. There may be some discomfort when the needle is inserted.
4. There are serious complications in less than 1% of amniocentesis procedures. The most serious complication is miscarriage. Other possible, but rare, serious complications include hemorrhage, infection, or injury to the fetus. Minor complications include cramping, vaginal spotting, slight leakage of amniotic fluid, and soreness where the needle was inserted. Early amniocentesis (12-15 weeks gestation) may have a slightly higher risk than standard amniocentesis (after 15 weeks gestation) for pregnancy loss, amniotic fluid leakage, and culture failure.
5. Fewer than 1 in 100 amniocenteses need to be repeated because not enough fluid is obtained the first time. Occasionally, even though fluid is obtained, a diagnosis cannot be made, and the amniocentesis needs to be repeated or further testing might be necessary.
6. The standard testing performed on an amniotic fluid sample is chromosome analysis, which can identify over 99% of chromosomal disorders, and AFP (alpha-fetoprotein) analysis, which can identify over 90% of open neural tube defects. Testing for other conditions will not be performed unless indicated in (1) above.
7. Normal test results do not guarantee the birth of a normal child. As in any laboratory test, there is a small possibility of error, and maternal cells may contaminate the sample. In addition, 3-5% of all pregnancies have birth defects which cannot be detected by testing amniotic fluid or by ultrasound examination.

Additional items of consent/refusal applicable to any of the above screening/testing

1. In the case of twins or other multiple fetuses, the results may pertain to only one of the fetuses.
2. In the case of abnormal diagnostic results, the decision to continue or to terminate the pregnancy is entirely mine.
3. The decision to consent to, or to refuse any of the above procedures/testing is entirely mine.
4. No test(s) will be performed and reported on my sample other than those authorized by my doctor; and any unused portion of my original sample will be destroyed within 2 months of receipt of the sample by the laboratory.
5. My doctor may release my pregnancy outcome or ultrasound and amniocentesis results to Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to be used for statistical analysis of the laboratory's performance.
6. LCAH, its subsidiaries and affiliated companies will disclose the test results ONLY to the doctor named below, or to his/her agent, unless otherwise authorized by the patient or required by law.
7. My signature below indicates that I have read, or had read to me, the above information and I understand it. I have also read or had explained to me the specific disease(s) or conditions(s) tested for, and the specific test(s) I am having, including the test descriptions, principles, and limitations. I have had the opportunity to discuss the purposes and possible risks of this testing with my doctor or someone my doctor has designated. I know that genetic counseling is available to me before and after the testing. I have all the information I want and all my questions have been answered.

YES: I REQUEST that Dr./or an associate physican _____ perform amniocentesis and/or the genetic screening or testing marked above. I understand and accept the conseqoences of this decision.

_____ _____ _____

Patient Signature | Date | Obtained by

NO: I DECLINE to have amniocentesis, and/or the genetic screening/testing offered to me. I understand and accept the consequences of this decision.

_____ _____ _____

Patient Signature | Date | Obtained by

California, Georgia, and New York have statutes requiring laboratories to send confidential results of certain genetic tests to state or federal health agencies for monitoring the detection of birth defects.

It is a standard of care for physicians to obtain informed consent for genetic testing. This model consent form is designed to address the requirements of New York State Civil Rights Law Section 79-L and Massachusetts General Law Chapter 111, Section 70G. Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies require that all reproductive genetic testing sent to any of our laboratories be accompanied by the signed attestation on the front of this Test Requisition Form. Relevant educational materials are also available through LCAH.

BRCAssure℠ Test Components	Comprehensive *BRCA1/2* Analysis: Includes full gene sequencing and duplication/deletion testing of *BRCA1/2* genes	Ashkenazi Jewish *BRCA* Panel: Includes screening for three known pathogenic variants; two in *BRCA1* gene, one in *BRCA2* gene

rep-239-v17-112013

Integrated Oncology Requisition

Integrated ONCOLOGY
Laboratory Corporation of America Holdings

New York Client Services
(800) 447-5816
fax: (212) 689-9532

Highlighted fields are required.

DIAGNOSTIC
www.integratedoncology.com

PATIENT

PATIENT LAST _____ FIRST _____ MIDDLE _____ ☐ Male ☐ Female Date of Birth ____/____/____
Address _____ Home Phone _____ Work Phone _____
_____ Social Security # _____
City _____ State ____ Zip _____ Lab # _____ Hospital # _____

Referring Physician _____ Treating Physician _____ Phone # _____
Referring Physician Phone/pager _____
NPI # _____ Taxonomy # (NPI Specialty Code) _____ Physician/Authorized Signature _____

CLIENT

SPECIMEN AND CLINICAL INFORMATION

Specimen Information

Hospital status when sample collected: ☐ Inpatient ☐ Outpatient ☐ Non-hospital
ID#(s): _____ Body Site/ Description: _____
Collection Date: _____ Time: _____ Send Date: _____

NOTE: If multiple blocks are submitted, the best block will be selected.
☐ Paraffin Block: (attach H&E with each submitted block) ☐ Formalin ☐ Other: _____
Required for Breast Cancer: Time to Tissue Fixation: _____ Tissue Fixation Time: _____
☐ Slides _____ ☐ Smears _____
☐ Bone Marrow _____ ☐ Peripheral Blood/Stem Cell Product _____
☐ Urine: Voided Urine _____ ☐ Bladder Washing _____ ☐ Wet Tissue

Return Material To: ☐ Ordering Client ☐ Other: Name/Address (indicate below)
_____
_____
_____

Clinical Information

Diagnosis/Signs/Symptoms + ICD-CM (must be stated at Date of Service (Highest Specificity Required))
_____
_____
Clinical Data: (attach clinical history and pathology reports)

TESTS AND SERVICES

Tumor Analysis

Immunohistochemical tumor analysis with professional interpretation. Integrated Oncology pathologist will select antibodies (range 1–25) that are medically necessary depending on the diagnosis under consideration:

☐ Acute leukemia
☐ Adenocarcinoma vs. mesothelioma
☐ Bladder vs. prostate carcinoma
☐ Carcinoma of unknown primary site
☐ Carcinoma vs. melanoma
☐ Germ cell tumor
☐ GIST
☐ Hepatoma/cholangio vs. met. carcinoma
☐ Hodgkin vs. NHL
☐ Lung vs. breast
☐ Lymphoma phenotype
☐ Lymphoma vs. carcinoma
☐ Lymphoma vs. reactive hyperplasia
☐ Molar vs. non-molar pregnancy
☐ Neuroendocrine neoplasm
☐ Paget's disease vs. melanoma vs. SqCC
☐ Pituitary neoplasm
☐ Plasma cell neoplasm
☐ Prostate carcinoma vs. adenosis
☐ Small cell vs. non-small cell carcinoma
☐ Small round cell tumor (e.g., Ewing's, PNET)
☐ Soft tissue tumor
☐ SqCC vs. melanoma vs. AFX
☐ Squamous cell vs. adenocarcinoma of lung
☐ Undifferentiated tumor

Provisional/Differential Diagnosis(es): _____

TESTS AND SERVICES, CONTINUED

Molar Pregnancy

☐ DNA Ploidy/S-Phase & p57 (IHC) ☐ DNA Ploidy/S-Phase
☐ ☐ If diploid, reflex to p57 (IHC)

Lymph Node and Bone Marrow Micrometastases Detection

Integrated Oncology pathologist will select antibodies (range 1–4 per block) that are medically necessary depending on the tumor type:
☐ Breast ☐ Melanoma ☐ Neuroblastoma ☐ Other _____

UroVysion® FISH

☐ UroVysion® FISH (MD Review) ☐ UroVysion® FISH (PhD Review)
Urine Collection Method: ☐ Voided ☐ Catheterized ☐ Bladder Wash

Infectious Agents (IHC)

☐ Adeno ☐ CMV ☐ EBV (LMP1) ☐ HBcAg ☐ HBsAg ☐ HCAg
☐ H. pylori ☐ HSV ☐ Parvovirus* ☐ P. carinii ☐ 1C8D ☐ VZV

In Situ Hybridization (ISH)

☐ EBV (EBER) ☐ PML (JC) ☐ KAPPA ☐ LAMBDA

HPV Tissue Testing
☐ HPV Screen ☐ HPV if Screen Positive, do Subtype (6/11, 16/18, 31/33)
☐ HPV Subtype Only ☐ HPV Screen & Subtype

Consultative Services (Send pathology report)

☐ Pathology consultation and report on referred material requiring slide preparation
☐ Pathology consultation and report on referred slides
☐ IHC staining with brief summary interpretation
☐ Technical component (antibody stain) only

Individual Antibodies

Specify: (The most current Antibody Library is available at www.integratedoncology.com/ab)
_____
_____

*Investigational Use Only. UroVysion® is a registered trademark of Abbott Laboratories.

Integrated Oncology is a brand used by both Accupath Diagnostic Laboratories, Inc. and Esoterix Genetic Laboratories, LLC, wholly-owned subsidiaries of Laboratory Corporation of America® Holdings.

BILLING INFORMATION

☐ BC/BS ☐ HMO ☐ PPO ☐ Indemnity ☐ Network ☐ Medicaid
☐ Medicare ☐ Medical Group/IPA ☐ Hospital/Facility Bill # _____ ☐ Self-Pay
☐ Billing Information Attached (Please include a copy of insurance card or face sheet.)
Do not attach credit card information to this form.

Insurance Company Name _____
Policy # _____ Group # _____
Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Patient Signature _____ Date _____

INTEGRATED ONCOLOGY INTERNAL USE ONLY

By signing this form, I hereby authorize Laboratory Corporation of America® Holdings (LCAH), its subsidiaries and affiliated companies to furnish any designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to LCAH. I understand that I am responsible for any amounts not paid by insurance for services, including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.

ano-166-V6-0214

NeoGenomics Requisition

Hallmark Health
Providing the highest quality health care in our area.

HEMATOPATHOLOGY REQUISITION

585 Lebanon St., Melrose, MA 02176
PH: (781) 979-3839 • FAX: (781) 979-3142

NeoGenomics Laboratories

Client Information

MELROSE-WAKEFIELD HOSPITAL - 2438
585 Lebanon St.,
Melrose, MA 02176
PH: (781) 979-3839
FAX: (781) 979-3142

Requisition completed by: _____ Date _____
Ordering Physician (please print): _____
Ordering Physician Signature: _____

Specimen Information

Specimen ID#: _____
Fixative/Preservative: _____
Collection Date: ____/____/____ Collection Time: _____ ☐ AM ☐ PM
Body Site: _____ ☐ Primary ☐ Metastasis
If Metastasis, please list Primary: _____
☐ Bone Marrow: Green Top(s) _____ Purple Top(s) _____
☐ Peripheral Blood: Green Top(s) _____ Purple Top(s) _____ Other _____
☐ Fresh Tissue (Media Type required): _____
☐ Fluid: CSF _____ Pleural _____ FNA _____ Other _____
☐ Other: _____

Patient Information

Patient Name (Last, First): _____
Date of Birth: MM _____ / DD _____ / YY _____ Sex: ☐ Male ☐ Female
Medical Record #: _____
Visit #: _____

Clinical Diagnosis: _____
(Please attach all relevant clinical history and pathology reports)
☐ New Diagnosis ☐ Relapse ☐ In Remission
☐ See Attached for Patient Demographics

Billing Information

*Please attach face sheet and front/back of patient coverage card(s)

Bill to:
☐ Insurance
☐ Pathology Group
☐ Hospital

Patient Status (Choose 1): ☐ In-Patient ☐ Out Patient ☐ Non-Hospital Patient

Coding Information

Diagnosis Code/ICD-9 Code (required): _____

Hematopathology Testing

Flow Cytometry

☐ Standard Leukemia/Lymphoma Panel
☐ Extended Leukemia/Lymphoma Panel with complete plasma cell evaluation
☐ PNH (Global)
☐ Additional Global Markers _____

Cytogenetics

☐ Oncology Chromosome Analysis
☐ Other: _____

Other Testing

☐ NeoTYPE™ AML Prognostic Profile
☐ NeoTYPE™ CLL Prognostic Profile
☐ NeoTYPE™ Lymphoma Profile
☐ NeoTYPE™ MDS/CMML Profile
☐ NeoTYPE™ Spliceosome Mutation Profile
☐ **NeoARRAY™ SNP/Cytogenetic Profile**

Please view back of requisition for all panel / profile components

Comments: _____

FISH

Hematologic FISH Panels
☐ MDS - For unexplained Anemia/Cytopenia
☐ MM/MGUS
☐ CLL
☐ NHL
☐ MPN
☐ AML
☐ Eosinophilia

Individual Probes
All panel probes can be ordered individually by using the "Other" write-in box.
☐ ALK/Lymphoma (2p23)
☐ BCR/ABL/ASS t(9;22)
☐ PML/RARA t(15;17)
☐ Other _____

Molecular Genetics

☐ ABL1 Kinase (Gleevec® resistance)
☐ B-Cell gene rearrangements
☐ B-Cell & T-Cell gene rearrangements
☐ BCR-ABL1, t(9;22) - ☐ Reflex to ABL1
☐ CEBPA
☐ CLL Molecular Prognostic Panel
☐ FLT3
☐ JAK2 V617F - ☐ Reflex to JAK2 Exon 12-14
☐ MPN Reflex Panel
☐ NPM1
☐ PML-RARA, t(15;17)
☐ Other _____

For a complete list of our test menu please visit www.neogenomics.com

Please see back of requisition for full test descriptions, specimen requirements and billing information. ONC REQ • Rev. 02.14.14

Hallmark Health System

Laboratory/Imaging Requisition

Patients please report to registration before going to the laboratory at the main campuses

V#_____ LAB USE ONLY

Lawrence Memorial Hospital	Malden Family Health	101 Main Street Medford	Melrose-Wakefield Hospital
Lab 781-306-6650	Lab 781-979-3151	781-391-2121	Lab 781-979-3151

FOR LABORATORY USE ONLY

SST	Red	Lav	Blue	Urine	Stool	Swab	Genp	Form

Ordering Physician:

Please print

Patient _____ (Last / First / Middle Initial)

Collection Date_____ Time_____

Street _____ D.O.B. _____ ☐ Male ☐ Female

City _____ State _____ Zip _____ I.D. _____ (Patient Hospital Medical Record Number)

Phone (___) ___-____ Patient Employer_____

1) Primary Insurance _____ Name and Address

Insurance Certificate # | Patient Suffix | Group Number | Mass Health Card Number | Sequence #

2) Secondary Insurance _____ Name and Address

Insurance Certificate # | Patient Suffix | Group Number | Mass Health Card Number | Sequence #

Subscriber Name_____ (Required) DOB ___/___/___ (Required) Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

I authorize HALLMARK HEALTH to release this billing information and to use this signature when processing my insurance claims. I also understand that I am responsible for any portion of my bill not covered by my insurance. Patient's Signature_____

When ordering tests for Medicare or Medicaid patients, please select only those tests which are medically necessary for the diagnosis or treatment of the patient. Medicare does not pay for routine screening tests.

Regarding Medicare patients: Asterisk (*) tests indicate limited coverage tests. If the diagnosis does not meet Medicare guidelines, patients must sign the Notice of Non Coverage Letter. I certify that the services requested on this document are medically necessary for the diagnosis and treatment of the above named patient.

X_____ (Physician Signature Required)

Instructions:

Comments to appear on report:

PCP:

Reflex testing performed at additional charge

Diagnosis, Sign or Symptom Required with each test ordered. ICD-9-CM codes should not be interpreted as proof of medical necessity.

☐ 789.00 Abdominal Pain, Unspecified
☐ 790.6 Abn Blood Chemistry Nec
☐ 794.8 Abn Liver Function Study
☐ 626.0 Absence of Menstruation
☐ 462 Acute Pharyngitis
☐ 285.9 Anemia Nos
☐ 413.9 Angina Pectoris Nec/Nos
☐ 716.90 Arthropathy Nos-Unspec
☐ 427.31 Atrial Fibrillation
☐ 724.5 Backache Nos
☐ 296.7 Bipolar Affective Nos
☐ 592.0 Calculus of Kidney
☐ 786.50 Chest Pain Nos
☐ 496 Chr Airway Obstruct Nec
☐ 428.0 Congestive Heart Failure
☐ 414.00 Coron Atheroscler Nos Type V
☐ 414.01 Coronary Atherosclerosis Of
☐ 786.2 Cough
☐ 436 CVA
☐ 311 Depression
☐ 250.00 Diab Mell w/o Comp Type II Or
☐ 787.91 Diarrhea
☐ 780.4 Dizziness
☐ 788.1 Dysuria
☐ 796.2 Elev Bl Pres w/o Hypertn
☐ 790.93 Elevated Prostate Specific A
☐ 780.60 Fever
☐ 599.70 Hematuria
☐ 272.4 Hyperlipidemia Nec/Nos
☐ 600.00 Hyperplasia of Prostate
☐ 401.9 Hypertension Nos
☐ 244.9 Hypothyroidism Nos
☐ 719.47 Joint Pain-Ankle
☐ 719.40 Joint Pain, NOS
☐ 729.5 Leg pain
☐ 724.2 Lumbago
☐ 162.9 Mal Neo Bronch/Lung Nos
☐ 780.79 Malaise & Fatigue
☐ 174.9 Malign Neopl Breast Nos
☐ 185 Malign Neopl Prostate
☐ 153.9 Malignant Neo Colon Nos
☐ 203.00 Multiple Myeloma Acute
☐ 202.80 Oth Lymphoma Extranodal & S
☐ 780.39 Other Convulsions
☐ 729.5 Pain in Limb
☐ 462 Pharyngitis
☐ 486 Pneumonia, Organism Nos
☐ 272.0 Pure Hypercholesterolem
☐ 714.0 Rheumatoid Arthritis
☐ 295.90 Schizophrenia Nos-Unspec
☐ 786.05 Shortness of Breath
☐ 729.81 Swelling of Limb
☐ 780.2 Syncope
☐ 451.9 Thrombophlebitis Nos
☐ 435.9 Trans Cereb Ischemia Nos
☐ 599.0 Urin Tract Infection Nos
☐ 788.41 Urinary Frequency
☐ 453.89 Venous Thrombosis Nec
☐ V76.44 **Screening PSA**

Additional Diagnosis (Please Print)

☐ Fasting	☐ Nonfasting	DIG*	☐	Date Time Dose	PT*	☐	Prothrombin Time*		
PANEL	(See Back for Components)	DIL	☐	Dilantin	PTT*	☐	PTT*	24 Hr. Urine For: ☐	
CMP	☐ Comp. Metabolic Panel	DAT	☐	Direct Coombs	RETIC*	☐	Reticulocyte Count*		
BMP	☐ Basic Metabolic Panel	FER*	☐	Ferritin*	RHOW	☐	Rhogam Workup	MICROBIOLOGY	
LIPR*	☐ Lipid* 12-14Hr Fast Req.	FOL	☐	Folate	RPR	☐	RPR	SOURCE:	
LIVER	☐ Liver Function Panel	GGT*	☐	GGTP*	RUB	☐	Rubella	BSTR ☐	Beta Strep/Genital
LYTE	☐ Electrolytes	BS*	☐	Glucose*	SED*	☐	Sed Rate*	STCD ☐	C.difficile
HEPA*	☐ Hepatitis Panel Acute*	GLYCO*	☐	Hemoglobin A1c*	SGOT	☐	SGOT (AST)	FUNGC ☐	Fungus Culture
PRNTL	☐ Prenatal Panel (General)	HDL*	☐	HDL*	SGPT	☐	SGPT (ALT)	GENP ☐	Genprobe (GC&CHLM)
AFPTM*	☐ Tumor Marker	HGB*	☐	Hemoglobin*	NA	☐	Sodium	GET ☐	Genital culture
ALB	☐ Albumin	HCT*	☐	Hematocrit*	THEO	☐	Theophylline	HSVRC ☐	Herpes Simplex
ALKP	☐ Alkaline Phosphatase	HBSAG	☐	Hep. B Surface Ag	TSH*	☐	TSH* (only)	STLAC ☐	Lactoferrin (stool WBC)
ANA	☐ ANA	HIV*	☐	HIV	TSHR*	☐	TSH with Reflex*	STOP ☐	O+P
HCG*	☐ Beta Sub Unit HCG*	HOMOCYS	☐	Homocysteine	FT4*	☐	Free T4*	SPC ☐	Sputum Culture/Gram Stain
BILID	☐ Bilirubin,Direct	IRON*	☐	Iron*	T4*	☐	Thyroxine*	STC ☐	Stool Culture
BILIT	☐ Bilirubin,Total	FE*/TIBC*	☐	Iron*/Iron Binding*	T3	☐	T3 Total	TC ☐	Throat Grp. A Strep
NBILI	☐ Neonatal Bilirubin <1mo. Old	LEAD	☐	Lead	T3U*	☐	T3 Uptake*	URMYC ☐	Urea & Mycoplasma
BUN	☐ BUN	LI	☐	Lithium	TP	☐	Total Protein	UC* ☐	Urine culture*
CA125*	☐ CA125*	LYME	☐	Lyme Antibody	TRIG*	☐	Triglycerides*	WC ☐	Wound Culture/Gram Stain
CA	☐ Calcium	MONO	☐	Mono Screen	TYSC	☐	ABO/Rh/AB Scr.	SOURCE REQUIRED:	
CRP	☐ CPRCARDIO ☐	OB*	Size/Sex	☐ ONCOL ☐ OBDIAG	TYPE	☐	ABO & RH	☐ Aerobic ☐ Anaerobic	
CBC*	☐ CBC Only* (No Diff)	PHOS	☐	Phosphorus	URIC	☐	Uric Acid	DIABETIC MANAGEMENT *CHECK EACH TEST*	
CBCR*	☐ CBC* (Reflex Diff)	PLT*	☐	Platelet Count*	B12	☐	Vitamin B12	LIPR* ☐	Lipid* 12-14 hr Fast Req
CBCD*	☐ CBC with Diff*	K	☐	Potassium	URINE FOR:			GLYCO* ☐	Hemoglobin A1c*
CEA*	☐ CEA*	PE	☐	Protein Electrophoresis	UAWM	☐	Rtn. Urine With Microscopic	UMALB ☐	Urine Microalbumin
CHOL*	☐ Cholesterol*	PSAD*	☐	PSA MONITOR*	UAR	☐	Rtn. Urine (Microscopic Reflex)	OTHER TESTS:	
CK	☐ CPK Total	PSASCR*	☐	PSA ANNUAL SCR.*	UA	☐	Rtn. Urine No Microscopic		
CREA	☐ Creatinine	PSAF*	☐	FREE PSA* (free & total)	UMALB	☐	Urine Microalbumin		
RADIOLOGY		☐ Mammogram-Screening w/Reflex*			☐ CT Scan Chest/Lung/Heart				
☐ Barium Enema				w/out Reflex*	☐ CT Scan Head/Brain*				
☐ Bone Density*		☐ Mammogram-Diagnostic w/Reflex*			☐ CT Scan Pelvis*			☐ Abdominal Ultrasound	
☐ Chest P/A & Lateral				w/out Reflex*	NUCLEAR MEDICINE			☐ Carotid Artery Ultrasound	
☐ Cervical Spine AP & Lat		☐ Upper GI Series			☐ Bone Scan w/Reflex*			☐ Pelvic Ultrasound w/Transvag*	
☐ KUB		☐ Upper GI Series and Small Bowel					w/out Reflex*	☐ Pelvic Ultrasound w/out Transvag*	
☐ Lumbar Spine		CT SCAN			☐ Breast Ultrasound w/Reflex*			☐ Pregnancy Ultrasound	
		☐ CT Scan Abdomen*					w/out Reflex*	☐ Renal Ultrasound	

Workflow Docs

1 – Laboratory Copy 2 – Radiology Copy 3 – Physician Copy

0011568 (Rev. 3/13)

MNEMONIC/CPT	DESCRIPTION/COMPONENTS
CMP/80053	Comprehensive Metabolic Panel - Albumin, Alk Phos, Total Bilirubin, CO2, NA, K, Cl, BUN, CA, Creat, Glucose, SGOT (AST), SGPT (ALT), Total Protein
BMP/80048	Basic Metabolic Panel - Na, K, Cl, CO2, Glucose, BUN, CA, Creat
LIPR*/80061	Lipid Panel* (Fasting - 12 hrs.) - Total Chol, Trig, HDL, LDL (Calculated), Coronary Risk Factor
LIVER/80076	Liver Function Panel (Hepatic Function Panel) - Albumin, Alk Phos, Bilirubin, (Total & Direct), SGOT (AST), SGPT (ALT), Total Protein
LYTE/80051	Electrolytes - Na, K, Cl, CO2
HEPA*/80074	Acute Hepatitis Panel* - HBsAg, HepCAb, HAAb IgM, Hep B Core Ab IgM
PRNTL 80055 (General)	Prenatal Panel - Type & Screen, Rubella, RPR, HBsAg, CBCD
PE	Serum Protein Electrophoresis - Albumin, Total Protein, Alpha 1 Globulin, Alpha 2 Globulin, Beta Globulin, Gamma Globulin, Interpretation
TSHR*	STSH* with *reflex:* If TSH<0.5 reflexes T3 and FT4; If TSH >4.67 reflexes FT4
CBC*/CBCR*	CBC* (Hemogram) - WBC, RBC, HGB, HCT, MCV, MCH, MCHC, RDW, PLAT CT. CBCR* will *Reflex* Diff if WBC <3,000 OR >20,000
CBCD*	Complete Blood Count* with Automated Differential *reflex* Manual Differential if indicated
UAR	Urinalysis will reflex microscopic if character is other than clear or if Prot, Bld, Est, Nitr is positive
Microbiology	Stool cultures will R/O Salmonella, Shigella, Ecoli 0157, and Campylobacter.
	Throat cultures will only screen for the presence of Beta Strep GRP A
	Susceptibility testing will be performed appropriately by organism at additional charge

NOTE: Asterisk * Tests indicate Limited Coverage Tests.
NOTE: Reflex testing performed at additional charge.

Please Visit Our Drawing Sites

LAWRENCE MEMORIAL HOSPITAL
Laboratory
170 Governors Avenue
Medford, MA 02155
Phone: 781-306-6850
Hours of Operation:
Monday - Friday, 7:00 a.m. - 6:00 p.m.
Saturday, 7:00 a.m. - 12:00 Noon

LAWRENCE MEMORIAL MEDICAL SERVICES
Drawing Station
101 Main Street, Suite 116
Medford, MA 02155
Phone: 781-391-2121
Hours of Operation:
Monday & Thursday, 7:00 a.m. - 7:00 p.m.
Tuesday, Wednesday & Friday, 7:00 a.m. - 5:00 p.m.

WOODLAND ROAD STONEHAM
3 Woodland Road First Floor
Suite 113
Stoneham, MA 02180
Phone: 781-665-3498
Hours of Operation:
Monday - Friday, 8:00 a.m. - 5:00 p.m.
Closed for Lunch, 12:30 p.m. - 1:30 p.m.

MEDICAL OFFICE BUILDING
50 Rowe Street
Melrose, MA 02176
Phone: 781-979-3296
Hours of Operation:
Monday - Friday, 7:00 a.m. - 5:00 p.m.

MELROSE-WAKEFIELD HOSPITAL LAB
585 Lebanon Street
Melrose, MA 02176
Phone: 781-979-3151
Hours of Operation:
Monday - Friday, 7:00 a.m. - 8:00 p.m.
Saturday & Sunday, 7:00 a.m. - 3:00 p.m.

MALDEN FAMILY HEALTH
1ST Floor
178 Savin Street
Malden, MA 02148
Phone: 781-338-7443
Hours of Operation:
Monday - Tuesday & Thursday,
8:00 a.m. - 4:00 p.m.
Closed for Lunch, 12:30 p.m. - 1:30 p.m.

READING MEDICAL CENTER
30 New Crossing Road
Reading, MA 01880
Phone: 781-213-5115
Hours of Operation:
Monday, 7:00 a.m. - 7:00 p.m.
Tuesday & Thursday, 7:00 a.m. - 5:00 p.m.
Wednesday & Friday, 7:00 a.m. - 4:00 p.m.

Hallmark Health System
Pathology Requisition Form

Date of Service ____ / ____ / ____

___ Lawrence Memorial Campus 781-306-6880 ___ Melrose Wakefield Campus 781-979-3135

Pathology#_____

V#_____

Unit#_____

Submitting Physician: _____
Other Physician: _____

PATIENT DATA Name_____ DOB ____ / ____ / ____

Address _____

Phone: (____) ____-_____ Social Security Number: ____ / ____ / ____ ☐ Male ☐ Female

INSURANCE Please provide a copy of the Insurance Card with requisition

PRIMARY INSURANCE ___BC/BS ___Medicare ___Medicaid ___Tufts ___HMOBlue ___Medex
___Secure Horizons ____GIC(State Hancock) ___Other _____

Certificate No.: _____ Patient Suffix _____ Group No.:_____

Mass. Health Card No.: _____ Sequence No.: _____

SECONDARY INSURANCE

Patient Suffix _____ Group No._____ Mass. Health Card No. _____ Sequence No. _____

SPECIMEN DATA

SOURCE 1: _____ SITE: _____ ☐Right ☐Left CLINICAL DX: _____

SOURCE 2: _____ SITE: _____ ☐Right ☐Left CLINICAL DX: _____

SOURCE 3: _____ SITE: _____ ☐ Right ☐ Left CLINICAL DX: _____

SOURCE 4: _____ SITE: _____ ☐Right ☐ Left CLINICAL DX: _____

SOURCE 5: _____ SITE: _____ ☐Right ☐ Left CLINICAL DX: _____

RELEVANT PRIOR BIOPSY/PAP SMEAR? _____

PLEASE CHECK RELEVANT SIGN(S)/SYMPTOMS(S)

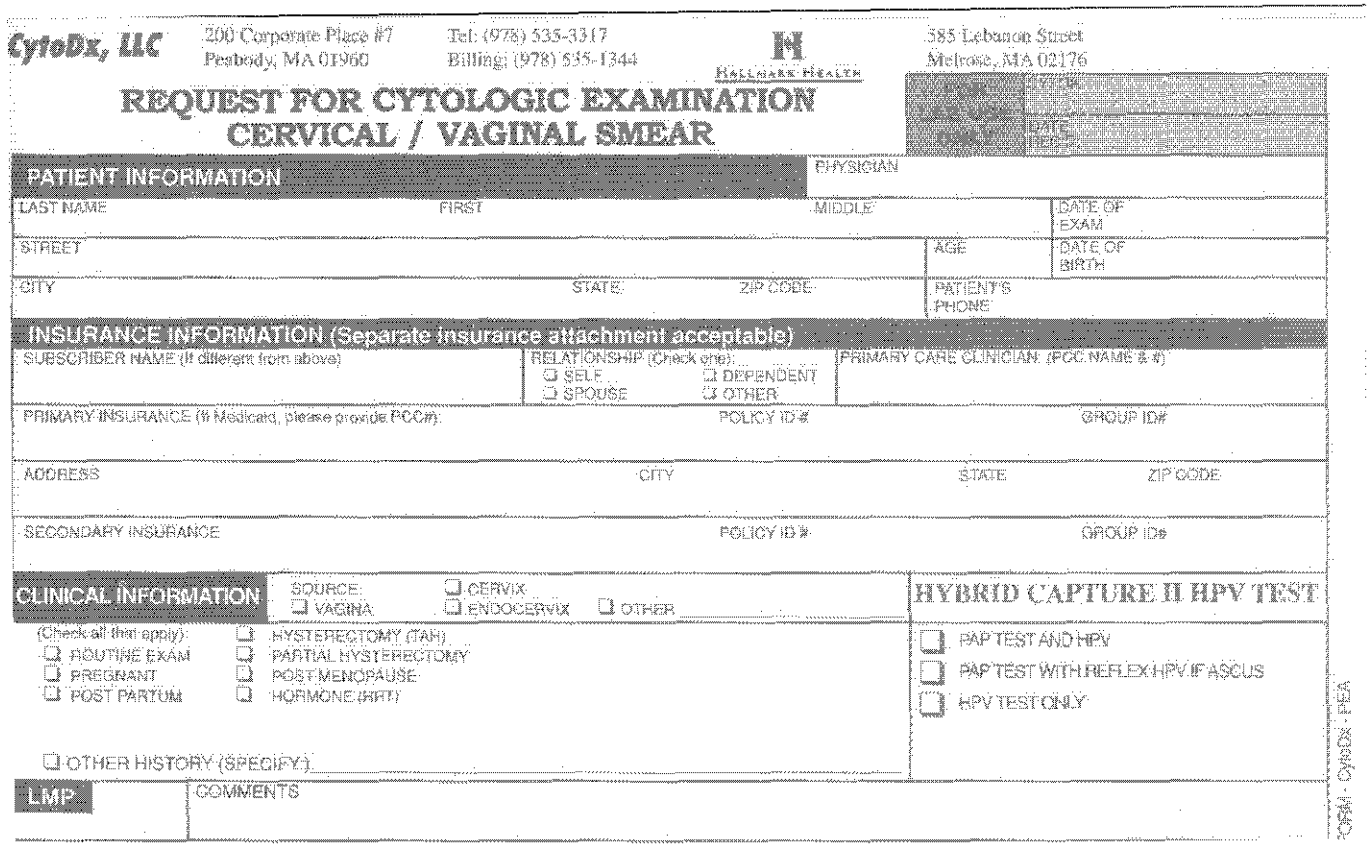
OB/GYN
____abnormal pap
____abnormal bleeding
____postmenopausal bleed
____irregular bleeding
____amenorrhea
____thickened endometrium
____endocervical polyp
____infertility
____other _____

UROLOGY
____hematuria
____elevated PSA
____calculus
____other _____

OTHER
____ _____
____ _____
____ _____

DERMATOLOGY
____keratosis
____skin lesion
____texture change
____other _____

Request for Cytologic Examination



CytoDx, LLC
200 Corporate Place #7
Peabody, MA 01960
Tel: (978) 535-3317
Billing: (978) 535-1344

Hallmark Health
585 Lebanon Street
Melrose, MA 02176

REQUEST FOR CYTOLOGIC EXAMINATION
CERVICAL / VAGINAL SMEAR

ACCN#
DATE REC'D

PATIENT INFORMATION

PHYSICIAN

LAST NAME | FIRST | MIDDLE | DATE OF EXAM

STREET | AGE | DATE OF BIRTH

CITY | STATE | ZIP CODE | PATIENT'S PHONE

INSURANCE INFORMATION (Separate insurance attachment acceptable)

SUBSCRIBER NAME (If different from above)

RELATIONSHIP (Check one):
☐ SELF ☐ DEPENDENT
☐ SPOUSE ☐ OTHER

PRIMARY CARE CLINICIAN: (PCC NAME & #)

PRIMARY INSURANCE (If Medicaid, please provide PCC#) | POLICY ID # | GROUP ID#

ADDRESS | CITY | STATE | ZIP CODE

SECONDARY INSURANCE | POLICY ID # | GROUP ID#

CLINICAL INFORMATION

SOURCE:
☐ VAGINA ☐ CERVIX ☐ ENDOCERVIX ☐ OTHER

(Check all that apply):
☐ ROUTINE EXAM
☐ PREGNANT
☐ POST PARTUM
☐ HYSTERECTOMY (TAH)
☐ PARTIAL HYSTERECTOMY
☐ POST MENOPAUSE
☐ HORMONE (HRT)

☐ OTHER HISTORY (SPECIFY):

HYBRID CAPTURE II HPV TEST

☐ PAP TEST AND HPV
☐ PAP TEST WITH REFLEX HPV IF ASCUS
☐ HPV TEST ONLY

LMP

COMMENTS

CytoDx - FEA