Molecular Diagnostics

ACCOUNT INFORMATION

Account name: _____

Address: _____ **City:** _____ **State:** _____

Zip code: _____ **Ph:** _____ **Fax:** _____

Molecular Diagnostics Laboratory
2330 Inwood Road, Suite EB3.304
Dallas, Texas 75235
LAB PHONE: 214-648-0960
LAB FAX: 214-648-0967
CUSTOMER SERVICE: 214-633-5227
CLIA #: 45D0861764
CAP #: 2664213

UTSouthwestern Medical Center
CLINICAL LABORATORY SERVICES

REQUIRED ORDER INFORMATION

BILL TO: ☐ Facility / Client ☐ Patient / 3rd party **– Billing information must be provided**

Patient Name: (Last, First, Middle)

Mother's Name: (if infant)

Date of Birth: | Sex: | Patient ID / MR#:

Hospital Inpatient Y / N | Collection Date: | Collection Time: AM PM

Ordering Physician (Full Name): | NPI:

Phone: | Pager: | FAX:

Clinical Indication for Tests Ordered:

PATIENT/3RD PARTY BILLING INFORMATION

ICD-10 Code(s)

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) available at: www.veripathlabs.com or by calling customer service at 214-645-7057 or toll free 877-887-8136 ☐ Signed ABN included

ICD-10 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle) | Date of Birth:

Patient's relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other | Responsible Party Address: (street, city, State, zip)

Sex: | Phone:

Employer's Name: | Employer's Phone:

Insurance Co. Name: | Insurance Co. Phone:

Insurance Co. Address:

Policy #: | Group #:

☐ Medicare ☐ HMO ☐ Other ☐ Medicaid ☐ PPO | Member ID#:

Referral Authorization/Precertification #:

Name: Date/Time:

SPECIMEN INFORMATION

☐ Whole Blood (EDTA preferred)
☐ Plasma (EDTA preferred)
☐ ThinPrep® (Must be Endocervical)
☐ Serum
☐ Bone Marrow (EDTA preferred)
☐ CSF
☐ Swab in Viral Media
☐ Urine
☐ Sorted Cells, source: _____
☐ Fixed Paraffin Embedded Tissue
Source: _____ Block # : _____
☐ Other: _____

TESTS REQUESTED

DNA MUTATION

☐ BRAF
☐ EGFR sequencing
☐ EGFR PCR
☐ FLT3
☐ IDH1, IDH2
☐ KIT melanoma
☐ KRAS
☐ NPM1
☐ NRAS
☐ p53

MUTATION PANELS

☐ Colon: KRAS, NRAS, BRAF
☐ Melanoma: BRAF, KIT, NRAS

OTHER ASSAYS

☐ B-Cell Clonality
☐ T-Cell Clonality
☐ 1p/19q LOH (brain tumors)
☐ MGMT for temozolomide
☐ Microsatellite Instability

IDENTITY ANALYSIS BY MICROSATELLITE DNA

☐ Specimen source identification

INFECTIOUS DISEASE by PCR

☐ Adenovirus
☐ *BK virus*
☐ Candida Auris
☐ Chlamydia and gonorrhea, urine
☐ Chlamydia and gonorrhea, ThinPrep
☐ CMV
☐ Covid (SARS-CoV2)
☐ EBV
☐ Enteric (stool) bacteria
☐ Enteric (stool) parasite
☐ Enteric (stool) virus
☐ Flu A and Flu B
☐ HBV
☐ HCV
☐ HHV-6
☐ HIV
☐ HPV high risk with genotyping, cervical
☐ HSV1 and HSV2
☐ Pneumocystis jirovecii
☐ RSV
☐ Monkeypox
☐ Vaginitis panel
☐ VZV

TRANSPLANT ANALYSIS

☐ Pre-Transplant STR analysis
Donor Name_____
Recipient Name_____
☐ Post-Transplant STR Analysis

COAGULATION MUTATION ANALYSIS

☐ Factor 2 (Prothrombin) mutation
☐ Factor 5 Leiden mutation
☐ MTHFR mutations

LAB USE ONLY

Transport Container: ___Yellow ___Green ___Purple ___Syringe ___Conical ___Red ___Blue ___Cup ___Trans Tube ___Block ___Slides ___Formalin ___Other:_____

Total # of specimens:_____

Transport Conditions: ☐Frozen ☐Slushy ☐Refrig ☐Room Temp

Destination: ☐Other_____ ☐Coag ☐Cytogen ☐HemePath ☐Flow ☐Hist ☐Mol Dx

Initials: