

SCCA GI CLINIC SERVICE REQUEST

For UW Pathology use

MRN:

Accession #

1 Patient Information	First Name	MI	Last Name
	Sex	DOB	SSN
	Patient Address		
	City	State	Zip
	Patient Phone #	Outside Facility Patient ID #	

2 Requesting Institution	Institution Name		
	Institution Address		
	City	State	Zip
	Person Completing Form		
	Phone	Fax	

3 Send Reports to	Requesting Physician (primary):	Phone	Fax	NPI #
	Referring Physician/Surgeon:	Phone	Fax	NPI #
	Referring Pathologist:	Phone	Fax	NPI #
	Additional reports to:	Phone	Fax	NPI #

4 Billing Information	Payment Options:	<input type="checkbox"/> Patient Insurance* (If outpatient) <input type="checkbox"/> Self-Pay (No insurance) <input type="checkbox"/> Institution/Client Billing <input type="checkbox"/> Split Billing / Medicare* (Pro to Patient, Tech to Client) <small>*Medicare Billing policy does not permit tech claims on laboratory testing for hospital inpatients/outpatients. These tech charges will be billed to the requesting institution.</small>					
	Primary Insurance			Secondary Insurance			
	ID/Policy #	Group #		ID/Policy #	Group #		
	Insurance Address		Phone	Insurance Address		Phone	
	City/State/Zip			City/State/Zip			
	Insured's Name	DOB	Relation to Pt:	Insured's Name	DOB	Relation to Pt:	

5 Specimen Information						
Tissue Media	Accession Number	Block ID	Slide ID	Specimen Description	Collection Date	

6 Prognostic Testing									
FISH	Breast	GI	Lung	Solid Tumor	IHC	Breast	GI	Lung	Solid Tumor
HER2neu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HER2neu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALK/EGFR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6 Required if clinical not provided		<input type="checkbox"/> Hold for Risk Management
Previous Surgery:	Last Menstrual Period:	
Chemo/Radiation Therapy:	Other/Comments:	
Transplant (type/date):		

7 Physician Signature Required	
Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services policies found at http://pathology.washington.edu/clinical/servicerequest	
Signature:	Date:

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Accessioned by:	Time Stamp: