Washington University Physicians
Washington University School of Medicine in St. Louis

PATHOLOGY: Histology & IHC

Ship samples to:

Washington University Diagnostic Laboratory Services
Attn: AMP Core Lab
509 S. Euclid Ave., St. Louis, MO 63110
Tel: (314) 747-1100 | Fax: (314) 747-5642

Office use only
Date/Time Received:
Accession Number:
Technician Initial:
Received:

This requisition has two pages, please complete it completely and accurately.

PHYSICIAN ORDERING TEST *(NPI required)*			PATIENT IDENTIFICATION		
Name:			Name Last:	First:	MI:
NPI:	Email:		DOB (mm/dd/yyyy):	Gender: Male Female	
Phone:	Fax:		Medical Record # (if applicable):		
Pager:					
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:

SPECIMEN INFORMATION

Date of biopsy:	Outside case number:
Other notes:	

REASON FOR TESTING *(required)*

Diagnosis:

ICD10 Code(s):

TESTING REQUESTED *(check all that apply)*

Acid Fast Bacteria	Actin, Muscle Specific	CD23	Cyclin D1	Hepatocyte(HepPar1)	p53
Alcian Blue 2.5	Actin, Smooth Muscle	CD3	Cytokeratin (Pan)	IgG4	p63
Alcian Blue/PAS	ALK-1	CD30	Cytokeratin 19	Inhibin	PAX-5
Bile	BCL-2	CD31	Cytokeratin 20	INI-1	PAX-8
Colloidal Iron	BCL-6	CD34	Cytokeratin 5/6	ISH EBER	Placental Alkaline Phosphatase
Congo Red	beta-Catenin	CD4	Cytokeratin 7	ISH Kappa	PMS-2
Copper	C-Kit	CD43	Cytokeratin 8/18	ISH Lambda	Progesterone Receptor (PR)
Elastic	CA 19-9	CD45, leukocyte common antigen	Cytokeratin CAM 5.2	Ki-67	Prostate Specific Antigen (PSA)
Fite	CA125		Cytokeratin-HMW (34BE12)	Lysozyme	Prostatic Acid Phosphatase
Fontana-Masson	Calcitonin	CD5	D2-40 Podoplanin	Mammaglobin	RCC
Gomori's methenamine silver (GMS)	Caldesmon	CD56	Desmin	Melan-A (Red)	S-100 Protein
Iron	Calretinin	CD57	E-cadherin	MLH-1	Synaptophysin
Jones' Sliver	Carcinoembryonic Antigen, Monoclonal	CD61	Epithelial Membrane Antigen	MLH-2	TdT
Melanin Bleach		CD68	Estrogen Receptor (ER)	MLH-6	Thyroglobulin
Mucicarmine	CD10 (CALLA)	CD68 Red	Factor XIIIa	MUM1 Protein	TTF-1
Pentachrome	CD138	CD7 (Leu9)	GATA 3	Myeloperoxidase	Vimentin
Periodic Acid Schiff (PAS)	CD15	CD79a	Glial fibrillary acid protein	Myogenin	WT-1
Periodic Acid Schiff (PAS) w/ Diastase	CD163	CD8	Glycophorin A	Napsin A	Other:
	CD1a	CD99	Glypican3	Neurofilament	
Reticulin, Gomori's	CD2	CDX2	GranzymeB	Neuron Specific Enolase	
Trichrome (routine)	CD20	Chromogranin A	Gross Cystic Disease Fluid Protein 15	Oct 3/4	
Von Kossa - Calcium	CD21	Collagen, Type IV		p16 INK4a	

ADDITIONAL COMMENTS:

Healthcare Professional Signature to Authorize Testing and Statement of Medical Necessity
I certify that the patient specified above and/or their legal guardian has been informed of the benefits, risks, and limitations of the laboratory test(s) requested and Informed Consent has been obtained, as well as any other consent from the patient required by my state in order to perform a genetic test on a specimen has been obtained. I further certify that the test(s) requested is/are medically necessary and the results of this test will be used in the medical management of the patient.

Signature:	Date:

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB (mm/dd/yyyy):

INSURANCE AND PRECERTIFICATION

Patients are responsible for non-covered services, deductibles, co-insurance, contract exclusions, non-authorized services, and remaining balances after insurance reimbursement. Washington University School of Medicine can only accept authorized Missouri and Illinois MEDICAID covered charges for genetic testing. Other out-of-state welfare programs cannot be billed. Please contact our Patient Accounts Manager office at 314-362-5641 or via e-mail at path-billing@email.wustl.edu for complete insurance filing information and the managed care contract list.

Prior Authorization Number:	ICD10 Code(s):	
CPT Codes and Units Authorized:		
ATTACH COPY OF INSURANCE CARD (if not available, complete the following)		
Policy Holder's Name:	Insurance Co. Name:	
Last First MI	Insurance Co. Phone:	
Policy Holder's Date of Birth (mm/dd/yyyy):	Plan Name:	
Relationship to patient:	ID#:	Group#:

SELF-PAY / PATIENT FINANCIAL ASSISTANCE

Patients who are self-pay should contact our office to arrange for payment. Financial assistance may be available. For more information, contact our Patient Accounts Manager office at 314-362-5641 or via e-mail at path-billing@email.wustl.edu.

AUTHORIZATION TO ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY FOR ACCOUNT

I authorize the disclosure of insurance benefit coverage and payment information to Washington University School of Medicine. I authorize Washington University School of Medicine to furnish any medical information requested on myself, or my covered dependents. I assign and authorize insurance payments to Washington University School of Medicine. I understand I am responsible for any co-pay, deductibles, or non-authorized services and remaining balances after insurance reimbursement. I understand I am fully responsible for payment of my account if Washington University School of Medicine is not a participant with my health plan, and/or my health plan does not fully reimburse medical services due to lack of authorization or medical necessity.

Signature of Patient or Guardian	Printed Name of Patient or Guardian	Date

Reference Laboratories: complete section below

INSTITUTIONAL BILLING

Institution Name:		
Contact Name:		
Email:		
Billing Address:		
City:	State:	Zip:
Phone:	Fax:	