

|                         |                  |                         |   |
|-------------------------|------------------|-------------------------|---|
| <b>For Lab Use Only</b> | Facility Name    | Ordering Physician Name |   |
|                         | Address          |                         | Last <span style="float: right;">First</span> |
|                         | City, State, Zip |                         | Physician NPI No. _____                       |
|                         | Phone ( )        | Report to Fax ( )       |   |

|   |  |   |  |
|---|--|---|--|
| Patient Name - <b>Required</b> (Last) (First) |  | Billing Info <input type="checkbox"/> <b>Copy of Front &amp; Back of Ins. Card Attached</b>   |  |
| Location <b>Unique Identifier or MRN</b>      |  | <input type="checkbox"/> Private Ins./PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Inpatient <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Client<br><input type="checkbox"/> Outpatient |  |
| CSN -   | DOB - <b>Required</b>                    | Sex<br>M F  |  |
| Patient's Phone Number ( )                    | Collection Date & Time - <b>Required</b> | Collected By - <b>Required</b>  |  |
| Copy to: First Name Last Name                 |  | Responsible Party (Please Print)  |  |
| Address:                                      |  | Street Address  |  |
| Ph. ( )                                       |  | City, State, Zip  |  |
| Fax ( )                                       |  | <b>ICD9 Code(s) - REQUIRED INFORMATION</b>  |  |

**Each individual test and CMS approved panel must have ICD-9 code(s) to indicate the medical necessity of the test requested.** Please document **all** applicable ICD-9 codes for the tests ordered. Tests for medicare patients must be screened to determine if an Advanced Beneficiary Notice (ABN) is required. An ABN should be provided to the patient if there is a reason to believe Medicare will not pay for the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests.

- Familial Gastric Cancer, Whole Blood (EDTA) (Unknown Mutation) **(CDH1)**
- CDH1 Known Mutation, Whole Blood (EDTA) One Exon - Specify the mutation: \_\_\_\_\_ **(CDH1)**
- Familial Gastric Cancer, Paraffin Embedded Tissue (Unknown Mutation) **(CDHPET)**
- CDH1 Known Mutation, Paraffin Embedded Tissue One Exon - Specify the mutation: \_\_\_\_\_ **(CDHPET)**

**KNOWN DIAGNOSIS OR SUSPECTED DIAGNOSIS**

Family History: \_\_\_\_\_

Are other relatives known to be affected with cancer?  No  Yes - Type of Cancer: \_\_\_\_\_

If yes, indicate their relationship to the patient: \_\_\_\_\_

**Genetic Counselor/Care Coordinator:** \_\_\_\_\_ **Phone #:** ( ) \_\_\_\_\_

List all relevant clinical symptoms and results of any applicable diagnostic tests: \_\_\_\_\_

Have any other relatives had molecular genetic testing?  No  Yes If yes, indicate the results [specific mutation(s) identified and the lab which testing was performed]: \_\_\_\_\_

If testing was performed at Stanford University Medical Center Clinical Laboratories, please indicate the patient name and date of birth:

\_\_\_\_\_ Last Name                      \_\_\_\_\_ First Name                      \_\_\_\_\_ Date of Birth

I have supplied information to the patient regarding genetic testing and the patient has given consent for genetic testing to be performed. I further confirm that this test is medically necessary for the diagnosis or detection of a disease, illness, impairment, syndrome or disorder, and results will be used in the medical management and treatment decision for the patient.

\_\_\_\_\_ Medical Professional Signature                      \_\_\_\_\_ Date

**Customer Service: 1-877-717-3733**

**Specimen Requirements:**

Specimen Type: Whole Blood

Container Type: Lavender-top tube (EDTA)

Required Volume: 2 mL

Special Handling: Mix by gentle inversion several times. **DO NOT CENTRIFUGE.** Transport original tube promptly, at room temperature.

**OR**

Specimen Type: Paraffin Embedded Tissue

Special Handling: Transport Paraffin Block at Room Temperature

**If Shipping on Friday, check for Saturday delivery**

Fax delivery notification to: (650) 724-4758

**SHIP TO:** Stanford's Pathology and Clinical Laboratory  
Attn: Specimen Processing  
3375 Hillview Avenue  
Palo Alto, CA 94304  
Phone: 1(877) 717-3733

Shipper's Responsibility: The shipper is required to comply with the rules and guidelines for transport of medical specimens as set forth by the United States government, the government of the country of origin and international regulatory agencies. Failure to follow instructions for packaging and shipping specimens can result in the delay, loss or destruction of your specimens. Stanford University Medical Center Clinical Laboratories will not be held responsible for any liability attributable to the shipper's improper actions or failure to comply with regulations.