



STANFORD

UNIVERSITY

MEDICAL CENTER

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IMMUNODIAGNOSIS

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MOLECULAR PATHOLOGY

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Payor <input type="checkbox"/> PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Client <input type="checkbox"/> Patient	Diagnostic Test .Immunodiagnosis
	For Lab Use Only
	Requisition #
Insurance Info: Attach a copy of front & back of Insurance card or face sheet	

Patient Name (Last) (First)		DOB
Social Security No. (Use last 6 digits or MRN)		Sex M F
Patient Address		Patient's Phone No. ()
City		State
Zip Code		
Institution Practice Name & Address		
Phone No. () Report Fax No. ()		
Ordering Physician -Print Name		NPI#
Copies to: Name & Address		

HMO Insurance Authorization # _____

Patient/health plan will receive 2 bills; technical (lab) and professional (M.D.) charges are billed separately.

ICD 9 Code(s) - REQUIRED INFORMATION			

Each individual test and CMS approved panel must have ICD-9 code(s) to indicate the medical necessity of the test requested. Please provide all applicable ICD-9 codes for the tests ordered. An ABN must be provided to the Medicare patient if there is a reason to believe Medicare will deny the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests.

Signature _____ Date & Time: _____

Patient History:

SPECIMEN INFORMATION: Paraffin block (preferred sample) or unstained sections				Check preservative		
Block / Slide / Case #	Date of Collection	Collection Time	Tissue Measurement (cm)	Formalin	B5	Bouins/Decal
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IMMUNOPHENOTYPING

For Malignancy (Antibody panel selected by pathologist) Specimen Date & Time of Collection: _____

<input type="checkbox"/> Infectious Organisms	<input type="checkbox"/> Adenovirus	<input type="checkbox"/> HBC	<input type="checkbox"/> HSV	<input type="checkbox"/> Parvovirus
Specify organism(s)	<input type="checkbox"/> Cat Scratch	<input type="checkbox"/> HBS	<input type="checkbox"/> ISH EBV	<input type="checkbox"/> Spirochetes
	<input type="checkbox"/> CMV	<input type="checkbox"/> HHV-8	<input type="checkbox"/> ISH HPV	<input type="checkbox"/> Toxoplasma (Neuropath)
			<input type="checkbox"/> SV40	

REQUESTED IHC TEST(S):

<input type="checkbox"/> Heart Panel Includes(C4d, C3d, CD3, CD31, CD68)	<input type="checkbox"/> Her2neu (FISH and IHC if necessary)
<input type="checkbox"/> CD117 (c-kit)	<input type="checkbox"/> Ki-67 (MiB1)
<input type="checkbox"/> DOG1	<input type="checkbox"/> Micro Satellite Instability Panel / Mismatch Repair Protein (MLH1, MSH2, MSH6, PMS2)
<input type="checkbox"/> ER/PR	
<input type="checkbox"/> EGFR	

Other: _____ For a complete list of stains visit: [IHC & Special Stains](#)

MOLECULAR PATHOLOGY

<input type="checkbox"/> EGFR Gene Mutation Panel (EGFRP)	<input type="checkbox"/> Micro Satellite Instability (MSI) Mutation Analysis (Submit a normal block or peripheral blood (ETDA) with tumor sample) (TMS)
<input type="checkbox"/> KRAS (KRAS)	<input type="checkbox"/> Other: _____ For a complete list of tests visit: Molecular Pathology