Clinical Molecular and Genomic Pathology

Website: http://ukhealthcare.uky.edu/genomics/
Phone: 859-323-5327 Fax: 859-257-0029
Email: cmgp@uky.edu
Shipping Address: 800 Rose Street, HA619
Lexington, KY 40536-0293

Hematologic Malignancy Test Requisition Form

Patient Information

First Name: _____ Last Name: _____

Address: _____

_____

_____

Phone: _____

MR#: _____

DOB (MM/DD/YYYY): _____

Gender: ◯ Male ◯ Female

Clinical Information

Diagnosis (Required): _____

_____

_____

Sample Information

◯ Peripheral Blood ◯ Bone Marrow

Collection Date/Time: _____

Collector: _____

Test Requested

◯ Hematologic Malignancy Panel (94 Genes)

◯ FLT3-ITD

◯ FLT3-TKD

◯ NPM1

◯ CEBPA

Referring Physician

Name: _____

Address: _____

_____

_____

Phone: _____ Fax: _____

Email: _____

Requesting Physician/Genetic Counselor/Other Contact Name:

_____

Phone: _____ Email: _____

Referring Physician Signature (Required):

_____

Billing Information

◯ Medicaid/Medicare

◯ Commercial Insurance
Pre-Authorization (Required): _____

◯ Patient Responsibility

Note:

- Provide all billing related information.
- For commercial insurance, preapproval required. Test will not be performed until preapproval is obtained.
- For Medicaid/Medicare, medical necessity MUST be provided.

Official Use Only

Received by: _____

Comments: _____

_____

_____