Knight Diagnostic Laboratories

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Questions? (855) 535-1522

Infectious Disease / Post-Transplant Test Requisition

Patient Information

Patient Last Name
Patient First Name
Street Address
City, State, Zip
Phone DOB / /
Fax ☐ Male ☐ Female
ID/MRN #
Hospital In-Patient ☐ Yes ☐ No

Ordering Healthcare Provider Information

Full Name
NPI
Office/Facility Name
Address
City, State, Zip
Phone Fax
Account #
Notes

Physician Signature Date

Send additional copies of test results to:

Healthcare Provider Name Provider Phone Fax
Healthcare Provider Name Provider Phone Fax

Billing Information - Select One Billing Method

Billing is done in accordance with the information provided below and OHSU Policy. Appropriate areas must be completed or referring laboratory/physician will be billed.

☐ Self Pay
☐ Bill Insurance
Attach Copy of Insurance Card or Billing Face Sheet
☐ Bill Referring Provider or Institution
Invoice will be sent to Client Account and Address Listed Above

Primary Insurance Name
Primary Policy #
Primary Group #
Preauthorization #
Relation to Insured ☐ Medicaid ☐ Medicare
☐ Self ☐ Child ☐ Spouse ☐ Other_____

Secondary Insurance Name
Secondary Policy #
Secondary Group #
Preauthorization #
Relation to Insured ☐ Medicaid ☐ Medicare
☐ Self ☐ Child ☐ Spouse ☐ Other_____

Clinical Information

Specimen Type
☐ Blood
☐ Bone Marrow
☐ Heparin
☐ EDTA
☐ Plasma
☐ Urine
☐ CSF
☐ Swab of _____
☐ Other _____
☐ Paraffin Block/Slides
☐ DNA from*
☐ RNA from*

Paraffin Block/Slides ID _____
Tissue Source _____
WBC Count _____

ICD-10 (required)
Diagnosis Description
Date of Specimen Collection / /
Time of Specimen Collection : :

*DNA/RNA extraction must occur in a CLIA-certified lab or a lab meeting equivalent requirements.

Clinical Information

Pathology Department Hospital Name _____

Pathology Department Phone _____

Donor Name / ID _____

Donor Gender _____

Date of Transplant _____

Notes

Infectious Disease PCR Tests

	Code	Test Name		Code	Test Name
☐	3330	Herpes Simplex Virus 1 & 2 (HSV-1, HSV-2), PCR	☐		

Molecular Monitoring Tests

	Code	Test Name		Code	Test Name
☐	4020	BCR::ABL Kinase Domain Mutations (Sequencing) Include BCR::ABL RNA PCR Level: _____ Indicate Breakpoint: _____	☐	4734	JAK2 V617F Mutation, Quantitative
☐	4080	BCR::ABL RNA Quantitation, PCR *If negative, reflex to more sensitive digital PCR? ☐ Yes ☐ No	☐	4736	JAK2 Exon 12 Mutation Analysis
☐	4140	Calreticulin (CALR)	☐	5010	MPL Mutation Analysis
☐	4460	FLT3 Mutation Analysis	☐	5080	Nucleophosmin (NPM1) Mutation Analysis
☐	4600	Comprehensive Heme Panel	☐	5300	PML::RARA Quantitative RT-PCR
☐	4740	JAK2 V617F Mutation, Quantitative, w/Reflex to Calreticulin			

Post-Transplant Engraftment (Chimerism)

	Code	Test Name		Code	Test Name
☐	4380	Pre-Transplant, Donor	☐	4390	Post-Transplant, Sorted Cell Chimerism : (Select Antibody Below)
☐	4382	Pre-Transplant, Recipient		☐	CD3+
☐	4388	Post-Transplant Engraftment (Chimerism)		☐	CD19+
				☐	CD33+
				☐	Other:

Result Release

Results will be immediately available to the patient unless you mark the box below
☐ Do not release (I reasonably believe that an Information Blocking exception applies)
Comments / Requests: