Knight Diagnostic Laboratories

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Email: KDLClientServices@ohsu.edu
Shipping: 2525 SW 3rd Ave, Ste 350, Portland, OR 97201
Questions? (855) 535-1522

Infectious Disease / Post-Transplant Test Requisition

Patient Information

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

Physician Signature Date

Ordering Physician Information

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

Send additional copies of test results to:

Physician Name
Physician Phone Fax
Physician Name
Physician 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
3040	Adenovirus, PCR (Quantitative Viral Load)	3092	CMV, PCR (Qualitative)
3040	Adenovirus, PCR (Qualitative Viral Load)	3180	EBV, PCR (Quantitative Viral Load)
3050	BK Virus, PCR (Quantitative Viral Load)	3302	Hepatitis C Genotyping
3060	Bordetella pertussis/parapertussis, PCR	3330	Herpes Simplex Virus 1 & 2 (HSV-1, HSV-2), PCR
3090	CMV, PCR (Quantitative Viral Load)		

Molecular Monitoring Tests

Code	Test Name	Code	Test Name
4020	BCR-ABL Kinase Domain Mutations (Sequencing) Include BCR-ABL RNA PCR Level: ______ Indicate Breakpoint: ______	4740	JAK2 V617F Mutation, Quantitative, w/Reflex to Calreticulin
4080	BCR-ABL RNA Quantitation, PCR	4734	JAK2 V617F Mutation, Quantitative
4140	Calreticulin (CALR)	4736	JAK2 Exon 12 Mutation Analysis
4150	CEBPA Mutation Analysis	5010	MPL Mutation Analysis
4460	FLT3 ITD Mutation, Quantitative, PCR	5080	NPM1 (Nucleophosmin) Mutation Analysis
4600	Comprehensive Heme Panel	5300	PML-RARA Quantitative RT-PCR

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: