



Knight Diagnostic Laboratories

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 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

Ordering Physician 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:

Physician Name Physician Phone Fax
 Physician Name Physician Phone Fax

Billing Information - Select One Billing Method

Self Pay Bill Insurance
 Attach Copy of Insurance Card or Billing Face Sheet

Primary Insurance Name
 Primary Policy #
 Primary Group #
 Preauthorization #

Relation to Insured Medicaid Medicare
 Self Child Spouse Other _____

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.

Bill Referring Provider or Institution

Invoice will be sent to Client Account and Address Listed Above

Secondary Insurance Name
 Secondary Policy #
 Secondary Group #
 Preauthorization #

Relation to Insured Medicaid Medicare
 Self Child Spouse Other _____

Clinical Information

Specimen Type

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

Notes

Pathology Department Phone _____

Donor Name / ID _____

Donor Gender _____

Date of Transplant _____

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Infectious Disease PCR Tests

Code	Test Name	Code	Test Name
3302	Hepatitis C Genotyping	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	4736	JAK2 Exon 12 Mutation Analysis
4140	Calreticulin (CALR)	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
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: