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Molecular Oncology - Solid Tumor Test Requisition

Full Name Street Address City, State, Zip Phone DOB / / Address Male Female City, State, Zip Phone DOB / / Address Male Female City, State, Zip Phone Fax Male Female Hospital In-Patient Yes No Account # Notes Physician Signature Date Send additional copies of test results to: Physician Name Physician Name Physician Name Physician Name Physician Phone Fax Bill Cient Invoice will be sent to Client Account and Address Listed Above Primary Insurance Name Primary Policy # Primary Group # Preauthorization # Relation to Insured Self Child Spouse Other Self Child Spouse Other Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Time of Specimen Collection Time Time of Specimen Collection Time Time Time Time Time Time Time Time	Patient Information		Ordering Physician Information			
City, State, Zip Phone DOB / / Address Fax Male Female City, State, Zip Phone Phone DOB / / Address City, State, Zip Phone Fax Male Female City, State, Zip Phone Fax Notes Physician Signature Date Send additional copies of test results to: Physician Name Physician Name Physician Name Physician Name Physician Name Physician Phone Fax Bill Client Invoice will be sent to Client Account and Address Listed Above Primary Insurance Name Primary Insurance Name Primary Group # Preauthorization # Relation to Insured Self Child Spouse Other Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information Clinical Information DNA from DNA from DNA from Draffin Block/Slide Sections (10-15) Paraffin Bloc	Full Name		Full Name			
Phone	Street Address		NPI			
Fax	City, State, Zip		Office/Facility Name			
ID/MRN #	Phone	DOB / /	Address			
Account # Notes Physician Signature Date Send additional copies of test results to: Physician Name Physician Phone Fax Physician Phone Fax Bill Insurance Self Pay Bill Insurance Attach Copy of Insurance Card or Billing Face Sheet Invoice will be sent to Client Account and Address Listed Above Primary Insurance Name Secondary Policy # Secondary Group # Preauthorization # Preauthorization # Preauthorization # Relation to Insured Medicaid Medicare Self Child Spouse Other Self Child Spouse Other Self Child Spouse Other Self Child Spouse Other Ot	Fax	Male Female	City, State, Zip			
Physician Signature	ID/MRN #		Phone Fax			
Physician Signature Date Send additional copies of test results to: Physician Name Physician Name Physician Phone Self Pay Bill Insurance Attach Copy of Insurance Card or Billing Face Sheet Primary Insurance Name Primary Policy # Secondary Policy # Secondary Policy # Preauthorization # Preauthorization # Relation to Insured Medicaid Medicare Self Child Spouse Other Self Child Spouse Other Clinical Information DNA from* DNA from* DNA from	Hospital In-Patient	Yes No	Account #			
Send additional copies of test results to: Physician Name	•		Notes			
Physician Name Physician Name Physician Phone Physician Physicia	Physician Signature	Date				
Physician Name Billing Information Self Pay Bill Insurance Attach Copy of Insurance Card or Billing Face Sheet Primary Insurance Name Primary Policy # Preauthorization # Relation to Insured Self Child Spouse Other DNA from* DNA f	Send additional copie	s of test results to:				
Physician Name	Physician Name		Physician Phone Fax			
Self Pay Bill Insurance Attach Copy of Insurance Card or Billing Face Sheet Primary Insurance Name Primary Policy # Preauthorization # Relation to Insured Self Child Spouse Other DNA from* DNA from* Paraffin Block/Slide Sections (10-15)	·		Physician Phone Fax			
Attach Copy of Insurance Card or Billing Face Sheet Invoice will be sent to Client Account and Address Listed Above	Billing Information					
Primary Policy # Primary Group # Preauthorization # Relation to Insured						
Primary Group # Preauthorization # Relation to Insured	Primary Insurance Name		Secondary Insurance Name			
Preauthorization # Relation to Insured	Primary Policy #		Secondary Policy #			
Relation to Insured	Primary Group #		Secondary Group #			
Self Child Spouse Other	Preauthorization #		Preauthorization #			
Clinical Information DNA from* Whole Blood Other Paraffin Block/Slide Sections (10-15) Paraffin Block/Slides ID Tissue Source Contact Phone Contact Fax *DNA extraction must occur in a CLIA-certified lab, or a lab meeting Clinical Information ICD-10 (required) Diagnosis Description Current Medications Turrent Medications Date of Specimen Collection / /	Relation to Insured	Medicaid Medicare	Relation to Insured Medicaid Medicare			
DNA from* Whole Blood Other Paraffin Block/Slide Sections (10-15) Paraffin Block/Slides ID Current Medications Tissue Source Contact Phone Contact Fax *DNA extraction must occur in a CLIA-certified lab, or a lab meeting	Self Child	Spouse Other	Self Child Spouse Other			
Whole Blood Other	Clinical Information					
Contact Phone Contact Fax *DNA extraction must occur in a CLIA-certified lab, or a lab meeting Date of Specimen Collection / /			·			
Contact Phone Contact Fax *DNA extraction must occur in a CLIA-certified lab, or a lab meeting Date of Specimen Collection / /	Whole Blood		Diagnosis Description			
Contact Phone Contact Fax *DNA extraction must occur in a CLIA-certified lab, or a lab meeting Date of Specimen Collection / /	Other					
Contact Phone Contact Fax *DNA extraction must occur in a CLIA-certified lab, or a lab meeting Date of Specimen Collection / /	Paraffin Block/Slid					
Contact Phone Contact Fax *DNA extraction must occur in a CLIA-certified lab, or a lab meeting Date of Specimen Collection / /	Paraffin Block/Slides	ID	Current Medications			
*DNA extraction must occur in a CLIA-certified lab, or a lab meeting Date of Specimen Collection / /						
*DNA extraction must occur in a CLIA-certified lab, or a lab meeting	·					
"DNA extraction must occur in a CLIA-certified lab, or a lab meeting			Date of Specimen Collection / /			

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WI	says selected by an expert molecular pathologist based nen this option is selected for panels, KDL Pathologists v arges applied.	, ,	•
lorectal	Cancer	_	
Code	Test Name	Code	Test Name
4224	GeneTrails® Colon Mutation Panel (KRAS, BRAF, NRAS)	5000	Microsatellite Instability (MSI)
5440	GeneTrails® Comprehensive Solid Tumor Panel (124 genes)		Lynch Syndrome Germline Sequencing Panel - See Molecular Genetics Requisition
ST			
Code	Test Name	Code	Test Name
4110	BRAF Mutation Analysis (exon 15)	4500	GeneTrails® GIST Genotyping Panel
4199	cKIT (exons 9, 11, 13, 17) with reflex to PDGFRA		(23 Gene Next-Gen Sequencing Panel) for 'wild-type GISTs
5250	PDGFRA Mutation Analysis only (exons 12, 14, 18)		
iomas			
Code	Test Name	Code	Test Name
4650	IDH1 & IDH2 Mutation Analysis	7270	Glioma FISH Panel
5005	MGMT Methylation	!	- Deletion 1p/19q (FISH) - EGFR amplification (FISH)
4810	H3F3A Mutation Analysis		- Deletion 10q, monosomy 10 (FISH)
6515	Glioma Microarray - Targeted Region Panel		
lanoma		•	
Code	Test Name	Code	Test Name
4110	BRAF Mutation Analysis (exon 15)	4900	Melanoma Panel (BRAF, NRAS, and cKIT Mutation Analys
4210	cKIT Mutation Analysis (exons 11, 13, 17)	5100	NRAS Mutation Analysis (exons 1, 2)
4525	GNAQ and GNA11 Mutation Analysis	6520	Melenoma Microarray - Targeted Region Panel
n-Small	Cell Lung Cancer		
Code	Test Name	Code	Test Name
5120	GeneTrails® NSCLC Genotyping Panel (37 Gene Next-Gen Sequencing Panel) (Does not include ALK + ROS1)	4825	Lung Cancer Mini Panel ALK FISH - FFPE ROS1 FISH - FFPE EGFR Mutation Analysis (exons 18-21)
4480	GeneTrails® Solid Tumor Fusion Gene panel (Includes ALK, ROS1, and other Kinase genes)	FISH Tests o	ordered individually (on FFPE tissue sections):
4110	BRAF Mutation Analysis (exon 15)	8018	ALK FISH -FFPE (2p23)
4360	EGFR Mutation Analysis (exons 18-21)	8219	FGFR1 FISH - FFPE (for amplification)
4363	EGFR T790M Mutation Analysis (erlotinib resistance)	8500	MET FISH (for amplification)
7600	NSCLC FISH Panel (ALK, RET, ROS1, MET)	8700	RET (FISH) FFPE
4800	KRAS Mutation Analysis (exons 1,2)	8720	ROS1 (FISH) FFPE
id Tumo	rs		

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Other Solid	Other Solid Tumor Tests							
Code	Test Name	Code	Test Name					
4023	ALK Mutation Analysis (Exons 22-25 only) (For crizotinib resistance)	5005	MGMT Methylation					
4110	BRAF Mutation Analysis (exon 15)	5100	NRAS Mutation Analysis (exons 1, 2)					
4360	EGFR Mutation Analysis (exons 18-21)	4600	HRAS Mutation Analysis (exons 1,2)					
4650	IDH1 & IDH2 Mutation Analysis	5250	PDGFRA Mutation Analysis (exons 12, 14, 18)					
4800	KRAS Mutation Analysis (exons 1, 2)	5270	PIK3CA Mutation Analysis (exons 9, 20)					

Custom Sequencing Tests

Code	Test Name	Code	Test Name	
4810	H3F3A	4810	Other:	
4810	TP53 (Full gene)			

Solid Tumor FISH Tests

Code	Test Name	Code	Test Name	Code	Test Name
8018	ALK	8692	RB1	8098	MYC
8180	EGFR amplification	8100	COL1A/PDGFB t(17;22)	8720	ROS1
8300	HER2 (ERBB2) amplification	8218	FGFR1 amplification	8105	CSF1R
8642	PTEN (Del 10q, monosomy 10)	8500	MET amplification	8250	FUS
8115	CCND1	8700	RET	8580	N-MYC
8200	EWSR1	8616	CDKN2A (p16)	8774	SS18 (SYT);TX:18
8498	MDM2	8338	FGFR3 t(4;14)	8274	Deletion 1p/19q

Full Chromosome Study*

Code	Test Name	Code	Test Name	Code	Test Name
6460	Lymph Node Chromosome	6750	Spleen Chromosome Study	6810	Tumor Chromosome Study
	Study				
*Chromosome Studies will reflex to FISH if clinically relevant abnormalities are detected; appropriate charges will apply.					

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