UI Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, Iowa 52242
Toll Free: 866-844-2522
Local: 319-384-7212
Fax: 319-384-7213

Immunopathology-FISH Consult
Requisition

FOR CLIENT USE ONLY: Requisition Date:_____
Completed By: Accn#

FOR UIDL USE ONLY: UIDL Path #_____
UIDL MRN#

PART A - PATIENT INFORMATION - *Required*

Patient Name:
Street:
City: St: Zip:
Phone: ( )
Date of Birth: Gender: ☐M ☐F

PART B - PROVIDER INFORMATION - *Required*

Referring Institution:
Street:
City: St: Zip:
Phone: ( ) Fax: ( )
Referring Physician:
Referring Physician NPI:
Required Physician Signature:

PART C - SPECIMEN INFORMATION

DATE OF COLLECTION:_____

MATERIALS SUBMITTED: _____**BLOCKS (required)**
_____ **SLIDES (provide slides used for IHC if available)**

Required ICD-9 codes: 1) _____ **2)**_____ **3)**_____

Total Time in Formalin (required): _____(hours)

TISSUE SOURCE/SITE:** _____

****NOTE: Her2neu: Only breast tissue, 10% formalin fixed paraffin blocks are accepted.** Total time of tissue in formalin is required information and must be noted above. If IHC Her2Neu results are available please send results, and corresponding slides if possible. **ALK FISH: Only lung tissue, 10% formalin fixed paraffin blocks are accepted.** Submit formalin fixed paraffin embedded tissue to yield 3 unstained slides, each with 4 micron-thick sections. Provide a pathology report with each specimen.

CONSULTATION REQUESTED: (All consultations include interpretation)

☐ **Lung Cancer, ALK FISH** ☐ **Her2neu IHC** ☐ **Her2neu FISH**

PERTINENT CLINICAL HISTORY AND FINDINGS: _____

CLINICAL DIFFERENTIAL DIAGNOSIS: _____

PART D - SEND BILL TO:
- REQUIRED

PATIENT STATUS: ☐ **Inpatient** ☐ **Outpatient** ☐ **Non-Hospital Patient**

Referring HOSPITALS only:
☐ **Bill Hospital for Medicare Inpatients or Outpatients (per CMS effective 7-1-12).**
☐ Bill Hospital for Any inpatient.
☐ Bill Insurance (Complete billing information must be provided or referring institution may be billed)

All other referring INSTITUTIONS: Please indicate who the responsible billing party will be for this case.
☐ **Referring Institution** Name:_____ Phone: _____
☐ **Patient's Insurance** (Complete billing information must be provided or referring institution may be billed)

Please note that the **correct birth date of all policy holders** is required information. Please attach the following to the requisition:
(1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage, OR
(2) a printout with patient demographics and insurance information from your practice management system.

Primary Insurance Coverage Information
Insured by: _____
Claims Address: _____
City :_____ST:___ ZIP:_____
Policy/ID #: _____ Group #: _____
Name of Subscriber: _____DOB:_____
Relationship to Patient:

Secondary Insurance Coverage Information
Insured by: _____
Claims Address: _____
City :_____ ST:_____ Zip: _____
Policy/ID #: _____ Group #: _____
Name of Subscriber: _____DOB:_____
Relationship to Patient:

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.

The purpose of this form is to obtain information necessary for UIDL Pathology Department to perform consultations and/or testing. Failure to properly complete the form may cause delay in the processing of specimens. *FISH 8-12*