Clear

University of Nebraska Medical Center
REGIONAL PATHOLOGY SERVICES

Regional Pathology Services
University of Nebraska Medical Center
981180 Nebraska Medical Center
Omaha, Nebraska 68198-1180
www.reglab.org

Toll Free: 1.800.334.0459
Phone: 402.559.6420
Fax: 402.559.9497

MOLECULAR DIAGNOSTICS TEST REQUEST FORM

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

PATIENT LAST NAME	FIRST NAME	MI

DOB / /	GENDER ☐ MALE ☐ FEMALE	PT. ID# / ADDITIONAL INFO
SSN - -	BILL ☐ OFFICE/CLIENT ☐ PATIENT/PATIENT INSURANCE	

PATIENT INSURANCE
ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD AND ATTACH COPY OF FRONT OF DRIVERS LICENSE
IF UNABLE TO OBTAIN COPY OF REQUIRED INFORMATION ALL FIELDS BELOW ARE REQUIRED

GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR)

ADDRESS	CITY	STATE	ZIP

PRIMARY INSURANCE
☐ **MEDICARE IN-PATIENT** ☐ **MEDICARE OUT-PATIENT** ☐ **MEDICAID** ☐ **INSURANCE**

POLICY ID#	GROUP ID#

INSURANCE COMPANY	PHONE NUMBER

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP

EFFECTIVE DATE / /

DIAGNOSIS / MEDICAL NECESSITY (ENTER ALL THAT APPLIES)

ICD-9/10 #1	ICD-9/10 #2	ICD-9/10 #3

NOTICE: WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT RATHER THAN FOR SCREENING PURPOSES. **FOR MORE INFORMATION SEE reglab.org/billingcompliance/**

Accession #:_____

Date Rec'd: ____/____/____ # of Slides:_____

Collection Date _____/_____/_____ **Collection Time** _____ **AM PM**

PHYSICIAN PROVIDER: _____
(Indicate the Supervising Dr./P.A. or N. Pract.)

Account Number:_____

Account Name:_____

Address: _____

City, State, Zip: _____

Phone Number:_____

Fax Number:_____

SECONDARY / TERTIARY INS – ATTACH INFORMATION

☐ ABN ATTACHED ☐ PRIOR AUTHORIZATION ATTACHED

MOLECULAR DIAGNOSTIC TESTING

NOTICE: Additional reference laboratory testing may be required at the discretion of the pathologist to establish or confirm a diagnosis. If additional testing is needed the client or patient may receive an invoice for additional testing from the reference laboratory. ☐ **Check the box if additional reference laboratory testing is not desired.** Please note that a definitive diagnosis may not be possible.

CLINICAL INFORMATION

SOURCE:
☐ BLOOD
☐ BONE MARROW
☐ TISSUE_____
☐ OTHER_____

REASON FOR REFERRAL

_____
_____
_____
_____
_____

COMMENTS

_____
_____
_____
_____
_____

Attach all relevant clinical history, pathology/cytology report(s) and other applicable test reports.

Pharmacogenomics
☐ Abacavir Sensitivity Genotyping (HLA B*57:01)
☐ Allopurinol B*58:01
☐ Carbamazepine Sensitivity Genotyping HLA B*15:02 (Asian) and A*31:01 (European)

HLA Genotyping for Disease Association
☐ Ankylosing Spondylitis B*27
☐ Autoimmune Hepatitis (Type I)
☐ Autoimmune Thyroid Disease (AITD) DRB1*03 and DRB1*05
☐ Behcet's B*51
☐ Birdshot Chorioretinopathy A29
☐ Celiac Disease DQ2, DQ8
☐ HLA Disease Association
☐ Myelodysplastic Syndrome (MDS) DRB1*15
☐ Narcolepsy DQB1*06:02
☐ Psoriatic Arthritis C*06
☐ Rheumatoid Arthritis DRB1
☐ Sjorgren Syndrome
☐ Systemic Lupus Erythematosos (SLE)DRB1*15:01 and *03:01
☐ Vogt-Koyanagi-Harada Syndrome (VKHS) DRB1*04:05

Hematopoietic Stem Cell (HSC) Transplant
☐ Chimerism, Post Transplant
☐ Chimerism, Summary Report
☐ DNA Frozen Cell Prep
☐ HLA Antibody Single Antigen, Class I
☐ HLA Antibody Single Antigen, Class II
☐ HLA DNA Extract and Hold (for future testing)
☐ HLA HSC Flow Crossmatch Transplant Donor (ordered on donor)
☐ HLA HSC Flow T & B Lymphocyte Crossmatch (ordered on recipient)
☐ HLA HSC Recipient Donors Summary Report
☐ HLA HSC Related Verification Type, High Resolution
☐ HLA HSC Verification Type (ordered on recipient)
☐ HLA Type HSC Recipient, High Resolution
☐ HLA Type HSC Related Donor Initial Type
☐ HLA Type HSC Unrelated Donor (ordered on recipient)

HLA Solid Organ Transplant
☐ Crossmatch Transplant Donor
☐ DSA Summary Report
☐ HLA Antibody Special Request
☐ HLA Antibody Testing
☐ HLA CDC T & B Cell Crossmatch (recipient)
☐ HLA Virtual Crossmatch
☐ Post Transplant Donor Specific Antibodies
☐ Solid Organ HLA Flow T & B Lymphocyte Crossmatch (recipient)
☐ Solid Organ Living Donor HLA Type
☐ Solid Organ Recipient New Evaluation
☐ Solid Organ Recipeint Re-Evaluation

Inherited Disease Testing
☐ Alpha-1 Antitrypsin Mutation (Z and S Mutations)
☐ Cystic Fibrosis 39 Mutation Panel
☐ Hemochromatosis Mutation (p.C282Y, p.H63D)
☐ Factor II Mutation (Prothrombin g.20210G>A)
☐ Factor V Mutation (Leiden p.R506Q)
☐ Factor II/V Mutations (Prothrombin g.20210G>A/Leiden p.R506Q)
☐ Fragile X Mutation (FMR 1)

Infectious Disease Testing
☐ Adenovirus DNA Detection, Qualitative
☐ B. pertussis DNA Detection
☐ BK Virus DNA Detection, Quantitation (Plasma/Urine)
☐ BK Virus DNA Detection, Qualitative (Tissue)
☐ CMV DNA Detection, Qualitative
☐ CMV DNA Detection, Quantitation (Plasma)
☐ EBV DNA Detection, Qualitative
☐ EBV DNA Detection, Quantitation (Plasma)
☐ Enterovirus RNA Detection
☐ HCV Genotyping
☐ Herpes Virus Panel (HSV, CMV, EBV, VZV, HHV-6)
☐ HHV-6 DNA Detection, Qualitative
☐ HIV RNA Detection, Quantitation
☐ HSV DNA Detection
☐ JC Virus DNA Detection
☐ Norovirus RNA Detection (Stool)
☐ Parvovirus DNA Detection
☐ VZV DNA Detection

FOR DETAILED TESTING INFORMATION VISIT REGLAB.ORG

Testing Supplies

Regional Pathology Services furnishes specimen-collection supplies for use by clients that send tests to us.

Supplies are ordered online at reglab.org/customer-service/supply-orders/ testing supplies and log-on information may be obtained by calling Client Services
Toll Free 800-334-0459
Phone 402-559-6420

Courier Services

Regional Pathology Services offers an extensive courier network, which includes contracted land and air courier services. Contracted land specimen pickup is provided at no charge for specimens tested by Regional Pathology Services or our designated reference laboratories.

To inquire about scheduled stops and after hours courier service, call
Client Services Toll Free 800-334-0459
Phone 402-559-6420

If shipping specimens address to:
Regional Pathology Services
University of Nebraska Medical Center
668 S 41st St., MSB 3500
Omaha, NE 68105-1180

Transport Instructions:
Specimen Handling/Shipping
To ensure the safety of personnel and the community, proper handling of specimens for shipment is mandatory. Specimens will be rejected if submitted improperly. The shipper is responsible for the proper packaging and shipping of all specimens. Shippers must be trained and certified by their employer to be able to prepare and ship packages containing diagnostic specimens, biological substances and infectious substances. Rules of the various agencies involved may differ, and may change regularly. Specimen must have at least two patient identifiers and be packaged in sealed plastic bags to prevent leakage or contamination. Place accompanying paperwork in the bag pocket, away from the specimen. Practice universal blood and body fluid precautions when handling specimens.

For tests that require scheduling or special arrangements prior to specimen collection, refer to the Online Test Menu at reglab.org for more information.

Questions?
Contact client services at 800-334-0459