

## ADDITIONAL TEST REQUEST

**Please complete the BLANK FIELDS and fax request back to 405.715.4519**

Date: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

HPC CASE NUMBER: \_\_\_\_\_

**INCLUDE UPDATED BILLING INFORMATION:** (Include copies of Insurance Cards Front and Back)

HPC Client Name: \_\_\_\_\_

Requested By: \_\_\_\_\_ Your Name: \_\_\_\_\_

Send Results To: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

By signing this requisition, I agree to and authorize the indicated tests. Request must be signed by authorizing physician (or designee).

Authorized Signature: \_\_\_\_\_

### Requested Test

- HPV Testing (Clariant)
- KRAS/BRAF Mutation Analysis (Clariant)
- HER2/neu FISH (Clariant)
- Oncotype DX (Genomic Health)
- MLH1/MSH2 – Microsatellite Instability Study (Clariant)
- BCR/ABL PCR Study (Clariant)
- JAK2 PCR Assay (Clariant)
- IGH/BCL1-FISH Study (Clariant)
- Other \_\_\_\_\_