

**PATIENT**

PATIENT LAST \_\_\_\_\_ FIRST \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

\_\_\_\_\_ Social Security # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Lab # \_\_\_\_\_ Hospital # \_\_\_\_\_

**CLIENT**

Referring Physician \_\_\_\_\_ Authorized Signature \_\_\_\_\_

Referring Physician Phone/pager \_\_\_\_\_ NPI # \_\_\_\_\_ Taxonomy # (NPI Specialty Code) \_\_\_\_\_

Treating Physician \_\_\_\_\_ Treating Physician Phone # \_\_\_\_\_

**SPECIMEN AND CLINICAL INFORMATION**

**Specimen Information**

Hospital status when sample collected:  Inpt  Outpt  Non-hosp

ID#(s): \_\_\_\_\_ Body Site: \_\_\_\_\_

Collection Date: \_\_\_\_\_ Time: \_\_\_\_\_ Send Date: \_\_\_\_\_

Multiple Specimens:  Best block will be selected unless "Test all" is checked  Test all

Paraffin Block: (attach H&E with each submitted block)

Formalin  Other: \_\_\_\_\_

Time to Tissue Fixation: \_\_\_\_\_ Tissue Fixation Time: \_\_\_\_\_

Slides \_\_\_\_\_  Smears \_\_\_\_\_

Bone Marrow \_\_\_\_\_  Peripheral Blood/Stem Cell Product \_\_\_\_\_

Urine: Voided Urine \_\_\_\_\_  Bladder Washing \_\_\_\_\_  Wet Tissue \_\_\_\_\_

Return Material To:  Ordering Client  Other: Name/Address \_\_\_\_\_

**Clinical Information**

Diagnosis(es)/Clinical Indication ICD9: \_\_\_\_\_

Clinical Data: (attach clinical history and pathology reports)

**TESTS AND SERVICES**

**Tumor Analysis**

Immunohistochemical tumor analysis with professional interpretation. Genzyme pathologist will select antibodies (range 1-25) that are medically necessary depending on the diagnosis under consideration:

Acute leukemia  Lymphoma vs. reactive hyperplasia

Adenocarcinoma vs. mesothelioma  Molar vs. non-molar pregnancy

Bladder vs. prostate carcinoma  Neuroendocrine neoplasm

Lung vs. breast  Paget's disease vs. melanoma vs. SqCC

Carcinoma of unknown primary site  Pituitary neoplasm

Carcinoma vs. melanoma  Plasma cell dyscrasia

Germ cell tumor  Prostate carcinoma vs. adenosis

GIST  Small cell vs. non small cell carcinoma

Hepatoma/cholangio vs. met. carcinoma  Small round cell tumor (e.g., Ewing's, PNET)

Hodgkin vs. NHL  Soft tissue tumor

Lymphoma phenotype  SqCC vs. melanoma vs. AFX

Lymphoma vs. carcinoma  Undifferentiated tumor

Provisional/Differential Diagnosis(es): \_\_\_\_\_

**TESTS AND SERVICES, CONTINUED**

**Molar Pregnancy**

DNA Ploidy/S-Phase & p57 (IHC)  DNA Ploidy/S-Phase

If diploid, reflex to p57 (IHC)

**Lymph Node and Bone Marrow Micrometastases Detection**

Genzyme Pathologist will select antibodies (range 1-4 per block) that are medically necessary depending on the tumor type:

Breast  Melanoma  Neuroblastoma

Other \_\_\_\_\_

**UroVysion® FISH**

Bladder Carcinoma

**Infectious Agents**

IHC		ISH	
<input type="checkbox"/> Adeno	<input type="checkbox"/> H. pylori	<input type="checkbox"/> EBV (EBER)	HPV Tissue Testing
<input type="checkbox"/> CMV	<input type="checkbox"/> HSV	<input type="checkbox"/> PML (JC)	<input type="checkbox"/> HPV Screen
<input type="checkbox"/> EBV (LMP1)	<input type="checkbox"/> P. carinii		<input type="checkbox"/> HPV if Screen Positive, do Subtype (6/11, 16/18, 31/33)
<input type="checkbox"/> HBcAg	<input type="checkbox"/> TOXO		<input type="checkbox"/> HPV Subtype Only
<input type="checkbox"/> HBsAg	<input type="checkbox"/> VZV		<input type="checkbox"/> HPV Screen & Subtype
<input type="checkbox"/> HCAg			

**Consultative Services**

Technical component (antibody stain) only

IHC staining with brief summary interpretation

Comprehensive pathology consultation and report with IHC analysis

Comprehensive pathology consultation and report on referred slides

Genzyme consultation by Juan Rosai, M.D.

**Individual Antibodies**

Specify: (The most current Antibody Library is available at [www.genzymegenetics.com/ab](http://www.genzymegenetics.com/ab))

\_\_\_\_\_

\_\_\_\_\_

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**BILLING INFORMATION**

BC/BS  HMO  PPO  Indemnity  Network  Medicaid

Medicare  Medical Group/IPA  Hospital/Facility Bill # \_\_\_\_\_  Self-Pay

Billing Information Attached (Please include a copy of insurance card or face sheet.)\*

\*Do not attach credit card information to this form.

Insurance Company Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Relation to Insured:  Self  Spouse  Child  Other \_\_\_\_\_

Patient Signature \_\_\_\_\_

**GENZYME GENETICS INTERNAL USE ONLY**

Non-Medicare Patients: I hereby authorize Genzyme Genetics to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Genzyme Genetics. I understand that I am responsible for any amounts not paid by insurance for reasons including, but not limited to, non-covered and non-authorized services. I permit a copy of this authorization to be used in place of the original.