

Highlighted fields are required.

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

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

Cell Block/FNA  
 Slides:  Unstained # of slides \_\_\_\_\_

Clinical Information

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

Staging/Grade:  
 Ductal  In-Situ  Invasive  Lobular  Metastatic

Tumor Size: \_\_\_\_\_ cm Nodal Status (positive/total): \_\_\_\_\_ / \_\_\_\_\_

Clinical Data: (attach clinical history and pathology reports)

TESTS AND SERVICES

Level of Service

(If Level of Service is not indicated, case will be performed as Technical Component Only.)

Technical Component Only  
 Global (Technical & Professional Components)

Note: HER2 analyses require formalin-fixed tissue. According to the ASCO/CAP guidelines, HER2 (IHC) with an equivocal (2+) score should be reflexed for FISH analysis.

Breast Markers (IHC)

- ER
- PR
- ER/PR
- HER2
- Ki-67
- p53
- HER2 (FISH) (Global ONLY)
- DNA Ploidy/S-Phase (Global ONLY)

Reflex Option (for Global Prognostic Cases ONLY)

- HER2 (IHC) reflex 2+ to FISH

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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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.