

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; Paraffin Block; Formalin; Other; Time to Tissue Fixation; Tissue Fixation Time

Clinical Information

Diagnosis(es)/Clinical Indication ICD9; Clinical Data: (attach clinical history and pathology reports)

IHC STAIN WITH iScope™ IMAGING, IHC STAIN ONLY (NO IMAGING); If neither of the above check boxes is marked, the case will be performed as an IHC STAIN ONLY (NO IMAGING).

INDICATE ANTIBODY STAINS TO BE PERFORMED

Grid of antibody stains to be performed including CK19, CK20, CK903, CMV, COLL IV, D2-40, DBA44, DESMIN, EBV, EBV (LMP1), E-CADHERIN, EGFR pharm Dx, EMA, ER, Factor VIII, Factor XIIIa, FLI-1, FSH, GASTRIN, GCDPF-15, GFAP, GH, GLUCAGON, GPH-A, GRANZYME B, HBcAg, HBsAg, HBME-1, HBP, HCAg, HCG, HepPar 1, HER2-HERCEPTEST, HHV8, HLA-DR, HMB-45, MLH-1, MSH2, MSH6, HPAP, HPL, HPV Screen by ISH, HPV Subtype by ISH, HSV, IgA, IgD, IgG, IgM, INHIBIN, INSULIN, KAPPA, KAPPA by ISH, Ki-67, LAMBDA, LAMBDA by ISH, LH, LIPASE, MAMMAGLOBIN, MART-1, M-cell TRYPTASE, Melan-A, MOC 31, MPO, MUC-1, MUC-2, MUM1, MURA, MYOD1, MYOGENIN, Neurofilament, NKI, NPM, NSE, OCT-2, OCT-3/4, p16, p504S, p53, p57, p63, Pan-Melanoma, PAX5, PC, PLAP, PML, PMS2, PNRA, PR, PROLACTIN, Prostate Triple Stain, PSA, PTH, S100, SMA, SMM, SOMA, SP-A, Synaptophysin, TdT, THROMBOMODULIN, THYROGLOBULIN, TIA-1, TOXO, TRAP, TRYPsin, TS, TSH, TTF-1, Uroplakin III, Vimentin, VIP, VZV, WT-1, ZAP-70

Comments; *The most current Antibody Library is available at www.genzymegenetics.com/ab

INDICATE ANTIBODY STAINS TO BE PERFORMED *

Grid of antibody stains to be performed including A-AT, ACTH, ACTIN, ADENO, AE1, AE1/AE3, AE3, AFP, ALK-1, AMYLOID A, B72.3, BCL-1, BCL-2, BCL-6, beta-Catenin, Ber-EP4, BOB-1, CA 19.9, CA 125, CALCITONIN, CALDESMON, CALPONIN, CALRETININ, CAM 5.2, CAM 5.2/AE1, CD1a, CD2, CD3, CD4, CD5, CD7, CD8, CD10, CD15, CD20, CD21, CD23, CD25, CD30, CD31, CD34, CD34 (QBEND-10), CD35, CD43, CD45, CD56, CD57, CD61, CD68, CD79a, CD99, CD117, CD138, CD163, CDX2, CEA, CEA (p), CHROMOGRANIN, CHYMOTRYPSIN, CK5,6, CK7, CK14, CK17

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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, Insurance Company Name, Policy #, Group #, Relation to Insured, 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.