



**CLIENT INFORMATION** PLEASE CHECK REQUESTING PHYSICIAN

CHECK ONE:  TC ONLY  GLOBAL  CONSULTATION

**PATIENT INFORMATION** (Green highlighted sections are required information)

Please attach the patient face sheet along with the front  See Attached and back of the primary and secondary insurance cards:

Name (Last, First): \_\_\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M F SS# \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Medical Record #: \_\_\_\_\_

I authorize the release of any medical and insurance information to EmeritusDX as needed to process claims for services provided. I also authorize EmeritusDX to pursue any necessary appeals related to full or partial payment denials for these services.

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

**CLINICAL INFORMATION**

COLLECTION DATE: \_\_\_/\_\_\_/\_\_\_

Clinical History: \_\_\_\_\_

**ICD-10 CODES**

Physician is required to submit ICD-10 diagnosis supported in patient's medical record as documentation of medical necessity.

Primary diagnosis codes:

- K21.00 Gastro-Esophageal reflux w/ esophagitis, w/out bleeding
- K29.70 Gastritis, unsp. w/out bleeding
- K52.9 Noninfective gastroenteritis and colitis, unsp.
- K57.30 Diverticulosis of large intestine w/out perforation or abscess w/out bleeding
- K63.5 Polyp of colon
- K64.0 First degree hemorrhoids
- R10.13 Epigastric pain
- R10.9 Abdominal pain, unsp.
- R11.13 Vomiting, w/ nausea, due to other spec causes
- R12 Heartburn
- R19.4 Change in bowel habit
- Z11.2 Encounter for screening and intestinal infectious diseases
- Z20.828 Contact with and (suspected) exposure to other viral communicable diseases
- R19.7/K92.1 Diarrhea, Unsp. w/ Hematochezia
- R19.7/R10.9 Diarrhea, Unsp. w/ Abdominal Pain
- R19.7/R19.5 Diarrhea, Unsp. w/ Other Fecal Abnormalities
- R19.7/R10.13 Diarrhea, Unsp. w/ Epigastric Pain

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

**BILLING INFORMATION**

Primary:  Medicare  Medicaid  Insurance  Patient  Client  
Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Ins. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Holder:  Self  Spouse  Child  Other  
Secondary:  Medicare  Medicaid  Insurance  Patient  Client  
Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Ins. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**BARRETT'S ESOPHAGUS (BE) FISH TESTING**

Specimen Sites:

- EG Junction
- All Esophageal BXs
- Specific Site(s) /specify by specimen label): \_\_\_\_\_

Tissue (if columnar mucosa present):

- BE FISH Tissue
- BE FISH COMP PANEL Tissue - BE FISH: ERBB2 (17q12), MYC (8q24), ZNF217 (20q13) and p16 (9p21); plus IHC Stains: Ki-67, p53, NTRK, TERT, MET, PTEN, AMACR

Cytology:

- BE FISH Cytology
- BE FISH COMP PANEL Cytology - BE FISH plus special stains: Cytology; Feulgen & Alcian Blue; pH 2.5; plus IHC stains: Ki-67, p53, AMACR

**TISSUE SPECIMENS SUBMITTED FOR PATHOLOGY EXAMINATION**

Specimen #	Biopsy Site(s)	Comments
A		
B		
C		
D		
E		
F		
G		
H		
I		
J		

**IHC**

- AB/PAS
- CD3
- Desmin
- C-Kit (CD117)
- H. pylori
- Ki-67
- P53
- PDL-1
- MMR Panel: (MLH1, MSH2, MSH6 & PMS2)

**MOLECULAR**

- KRAS therascreen®, FDA Approved \_\_\_\_\_ Tumor Block \_\_\_\_\_ Unstained Slides
- BRAF therascreen®, FDA Approved \_\_\_\_\_ Tumor Block \_\_\_\_\_ Unstained Slides

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above, (I) certify that the ordered tests are reasonable and medically necessary by the diagnosis or treatment of this patient's condition. (I) certify that, to the extent required by the laws of the state in which I provide healthcare services, I have obtained this patient's informed consent to undergo any testing requested hereby, and to have the results reported to me and (I) agree to provide you a copy of this persons signed and dated consent form per your request.

Physician/Authorized Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Signature required on this order or in the patient's medical record

**Please Discard Extra Labels**

1-Complete all required information on requisition. 2-Use appropriate number of labels provided. 3-Place 1 label on each specimen container (not on lid).

Site:  G13202 Name _____ DOB _____	Site:  G13202 Name _____ DOB _____	Site:  G13202 Name _____ DOB _____	Site:  G13202 Name _____ DOB _____	Site:  G13202 Name _____ DOB _____	Site:  G13202 Name _____ DOB _____
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**LINER**



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 Policy Holder:  Self  Spouse  Child  Other  
 Secondary:  Medicare  Medicaid  Insurance  Patient  Client  
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- Desmin  P53
- C-Kit (CD117)  PDL-1

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Name _____ DOB _____	Name _____ DOB _____	Name _____ DOB _____	Name _____ DOB _____	Name _____ DOB _____	Name _____ DOB _____
Site:  G13202	Site:  G13202	Site:  G13202	Site:  G13202	Site:  G13202	Site:  G13202
Name _____ DOB _____	Name _____ DOB _____	Name _____ DOB _____	Name _____ DOB _____	Name _____ DOB _____	Name _____ DOB _____

CommandLabForms.com 631-351-1331

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