GenesisLabs
LABORATORY OF CHOICE

1912 Rt 35 S, Ste 203, Oakhurst, NJ 07755
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genesislaboratory.com

Accession Info (For Genesis Lab Use)

Primarius Pathology

FISH Requisition

Date Specimen Collected: ____________ **Time Specimen Collected:** ____________ **STAT** ☐

Laboratory Use Only
Accession Number ____________ Date Received ____________ Time Received ____________

Practice Name ____________ Practice ID ____________
Ordering Physicians ☐ ____________
☐ ____________ ☐ ____________
☐ ____________ ☐ ____________
☐ ____________
☐ ____________
☐ ____________
☐ ____________

Practice Contact Information
Address ____________
City, State, Zip ____________
Phone ____________ Fax ____________

Surgery Center ____________ Address ____________ Phone ____________ Fax ____________

Patient and Insurance Information
(Currently Not Accepting Medicaid or Managed Medicaid Plans - Contract Pending)

First Name ____________ Last Name ____________ Middle Initial ____________ Gender* ____________
Address Line 1 ____________ Address Line 2 ____________ City ____________ State ______ Zip ______
DOB ____________ Cell/Home Phone ____________ Email ____________
Gender Identity* ____________ Race* ____________ Ethnicity* ____________ Sexual Orientation* ____________

Insured's Name ____________ Relationship to Patient ____________ Social Security # ____________
Home Phone ____________ Cell Phone ____________ DOB ____________ Gender ____________

Primary Insurance ____________
Group # ____________ ID# ____________
Address ____________
City ____________ State ______ Zip ______

Secondary Insurance ____________
Group # ____________ ID# ____________
Address ____________
City ____________ State ______ Zip ______

Test Panels

☐ Barrett's Esophagus FISH Panel ☐ Anorectal TERC FISH Panel

Source

☐ Jar 1 Pan Brushings
☐ Jar 2 Nodular Brushings (if present)
☐ Other ____________

Descriptive Findings ____________

Fixative (Please select one)

☐ ThinPrep®
☐ Alcohol-fixed
☐ Other ____________

Comments ____________

Cytology

☐ Esophageal Brushing ☐ Gastric Brushing
☐ Anorectal Brushing
☐ Other ____________

Anatomic Histology

Specimen Source/Site of tissue
A. ____________
B. ____________
C. ____________
D. ____________

Comments ____________

ICD-10 Codes

☐ C15.3 Malignant neoplasm of upper third of esophagus
☐ C15.4 Malignant neoplasm of middle third of esophagus
☐ C15.5 Malignant neoplasm of lower third of esophagus
☐ C16.0 Malignant neoplasm of cardia
☐ C16.1 Malignant neoplasm of fundus of stomach
☐ C16.2 Malignant neoplasm of body of stomach
☐ C18.9 Malignant neoplasm of colon, unspecified
☐ C21.0 Malignant neoplasm of anus, unspecified
☐ C21.8 Malignant neoplasm of overlapping sites of rectum, anus and anal canal
☐ K21.00 Gastro-esophageal reflux disease with esophagitis, without bleeding
☐ K21.01 Gastro-esophageal reflux disease with esophagitis, with bleeding
☐ K22.710 Barrett's Esophagus with Low Grade Dysplasia
☐ K22.711 Barrett's Esophagus with High Grade Dysplasia
☐ K22.719 Barrett's Esophagus with Dysplasia, unspecified
☐ Other ____________

This test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the ordering provider is authorized by law to order the test(s) requested herein.

____________ ____________
Signature of Physician or Other Authorized NPI Provider (REQUIRED) Date

Accessioner Initials 1 ____________ 2 ____________

*__Gender, Gender Identity, Race, Ethnicity, and Sexual Orientation__ are required by certain states and the CDC. *ICD-10 Codes are listed for information purposes only. It is the provider's responsibility to order tests that are medically necessary and in the best interest of the patient.* **For specimen pick up please call our Courier Line at 732-508-9154.**