

FISH Requisition

Date Specimen Collected: _____ **Time Specimen Collected:** _____ **STAT**

Laboratory Use Only
Accession Number _____ **Date Received** _____ **Time Received** _____

Practice Name _____ **Practice ID** _____ **Practice Contact Information**

Ordering Physicians _____ _____ _____ **Address** _____

_____ _____ _____ **Phone** _____

_____ _____ _____ **Fax** _____

Surgery Center _____ **Address** _____ **Phone** _____ **Fax** _____

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

Name _____ **Cell/Home Phone*** _____ **Date of Birth** _____

Full Address _____ **Email** _____

Gender* _____ **Gender ID*** _____ **Race*** _____ **Ethnicity*** _____ **Sexual Orientation*** _____

Insured's Name _____ **Relationship to Patient** _____ **Social Security #** _____

Cell/Home Phone _____ **Date of Birth** _____ **Gender** _____

Primary Insurance _____ **Secondary Insurance** _____

Group # _____ **ID#** _____ **Group #** _____ **ID#** _____

Address _____ **Address** _____

Test Panels

- Barrett's Esophagus FISH Panel** **Anorectal TERC FISH Panel** **HER-2 (GI)**

Source

- Jar 1 Pan Brushings **Descriptive Findings** _____
- Jar 2 Nodular Brushings (if present) _____
- Other _____

Fixative (Please select one) Cytology

- | | |
|--|---|
| <input type="checkbox"/> ThinPrep® Comments _____
<input type="checkbox"/> Alcohol-fixed _____
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Esophageal Brushing <input type="checkbox"/> Gastric Brushing
<input type="checkbox"/> Anorectal Brushing
<input type="checkbox"/> Other _____ |
|--|---|

Anatomic Histology

Specimen Source/Site of tissue A. _____ B. _____	Comments _____ _____ _____
---	---

ICD-10 Codes

- | | | |
|--|--|--|
| <input type="checkbox"/> C15.3 Malignant neoplasm of upper third of esophagus
<input type="checkbox"/> C15.4 Malignant neoplasm of middle third of esophagus
<input type="checkbox"/> C15.5 Malignant neoplasm of lower third of esophagus
<input type="checkbox"/> C16.0 Malignant neoplasm of cardia
<input type="checkbox"/> C16.1 Malignant neoplasm of fundus of stomach
<input type="checkbox"/> C16.2 Malignant neoplasm of body of stomach
<input type="checkbox"/> C18.9 Malignant neoplasm of colon, unspecified
<input type="checkbox"/> C21.0 Malignant neoplasm of anus, unspecified | <input type="checkbox"/> C21.8 Malignant neoplasm of overlapping sites of rectum, anus and anal canal
<input type="checkbox"/> K21.00 Gastro-esophageal reflux disease with esophagitis, without bleeding
<input type="checkbox"/> K21.01 Gastro-esophageal reflux disease with esophagitis, with bleeding
<input type="checkbox"/> K22.70 Barrett's esophagus without dysplasia
<input type="checkbox"/> K22.710 Barrett's esophagus with low grade dysplasia | <input type="checkbox"/> K22.711 Barrett's esophagus with high grade dysplasia
<input type="checkbox"/> K22.719 Barrett's esophagus with dysplasia, unspecified
<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____
<input type="checkbox"/> 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 _____

*Cell/Home Phone, Gender, Gender Identity (ID), Race, Ethnicity, and Sexual Orientation are required by certain states and/or 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.