INTERPACE DIAGNOSTICS
GUIDING TREATMENT. DELIVERING INNOVATION.

REQUISITION for TISSUE IDENTITY

TI

Include completed requisition with sample | **Client Services: 844-227-7621 | labsupport@interpacediagnostics.com**

For additional information, please contact Client Services

SPECIMEN INFORMATION

----SPECIMEN 1 ----------

COLLECTION DATE _____ (MM/DD/YYYY) TIME _____ (HH:MM) ☐ AM ☐ PM

ORGAN/TISSUE _____

PATHOLOGY NOS. _____ _____

DATE PULLED FROM STORAGE _____ (MM/DD/YYYY)

☐ HISTOLOGY SLIDES (H&E + 8 UNSTAINED)
#_____STAINED #_____UNSTAINED

☐ CYTOLOGY SLIDES (PAPANICOLAOU STAINED)
#___SLIDES FROM: (check box) ☐CYTOSPIN ☐SMEAR ☐CELL BLOCK

☐ PARAFFIN EMBEDDED TISSUE BLOCK

KNOWN CONTROL:

☐ BUCCAL BRUSH ☐ OTHER: _____

☐ BLOOD (EDTA, ACD-A, or ACD-B tube)

----SPECIMEN 2 ----------

COLLECTION DATE _____ (MM/DD/YYYY) TIME _____ (HH:MM) ☐ AM ☐ PM

ORGAN/TISSUE _____

PATHOLOGY NOS. _____ _____

DATE PULLED FROM STORAGE _____ (MM/DD/YYYY)

☐ HISTOLOGY SLIDES (H&E + 8 UNSTAINED)
#_____STAINED #_____UNSTAINED

☐ CYTOLOGY SLIDES (PAPANICOLAOU STAINED)
#___SLIDES FROM: (check box) ☐CYTOSPIN ☐SMEAR ☐CELL BLOCK

☐ PARAFFIN EMBEDDED TISSUE BLOCK

KNOWN CONTROL:

☐ BUCCAL BRUSH ☐ OTHER: _____

☐ BLOOD (EDTA, ACD-A, or ACD-B tube)

----SPECIMEN 3 ----------

COLLECTION DATE _____ (MM/DD/YYYY) TIME _____ (HH:MM) ☐ AM ☐ PM

ORGAN/TISSUE _____

PATHOLOGY NOS. _____ _____

DATE PULLED FROM STORAGE _____ (MM/DD/YYYY)

☐ HISTOLOGY SLIDES (H&E + 8 UNSTAINED)
#_____STAINED #_____UNSTAINED

☐ CYTOLOGY SLIDES (PAPANICOLAOU STAINED)
#___SLIDES FROM: (check box) ☐CYTOSPIN ☐SMEAR ☐CELL BLOCK

☐ PARAFFIN EMBEDDED TISSUE BLOCK

KNOWN CONTROL:

☐ BUCCAL BRUSH ☐ OTHER: _____

☐ BLOOD (EDTA, ACD-A, or ACD-B tube)

Use additional requisitions for additional specimens

PATIENT INFORMATION (may adhere patient label)

PATIENT NAME _____ (Last Name, First, MI)

DATE OF BIRTH _____ (MM/DD/YYYY) SEX: ☐ FEMALE ☐ MALE

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____ SSN or MRN _____

☐ PATIENT'S DEMOGRAPHIC INFORMATION ATTACHED (FACE SHEET)

BILLING INFORMATION

Party responsible for payment

☐ ORDERING INSTITUTION ☐ PRE-PAY (US check, cert. funds, etc.)

CLINICAL REPORTS

TEST REPORTS SUBMITTED FOR THIS CASE:

☐ PATHOLOGY REPORT ☐ OTHER: _____

☐ CYTOLOGY REPORT

PROVIDER INFORMATION

ORDERING INSTITUTION: _____

COLLECTING INSTITUTION: _____

ORDERING PHYSICIAN(S): NPI TEL FAX

FAX ADD'L REPORTS TO: _____

SIGNATURE

OrderTissue Identity testing by signing and dating this section.

PHYSICIAN SIGNATURE _____

PRINT NAME _____ DATE SIGNED _____ (MM/DD/YYYY)

STAFF CONTACT _____

PHONE _____ FAX _____

INTERPACE DIAGNOSTICS INTERPACE USE ONLY: Rec'd by: _____ Date/Time Rec'd: _____