INTERPACE™ DIAGNOSTICS
GUIDING TREATMENT. DELIVERING INNOVATION.

REQUISITION for ToxFinderTG

TF

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

____

____

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

Order ToxFinder testing by signing and dating this section.

SIGNATURE ______________________________________ (Authorized Delegate)

PRINT NAME ______________________ DATE SIGNED ____________ (MM/DD/YYYY)

STAFF CONTACT ____

PHONE ___________________________ FAX ____________________

INTERPACE USE ONLY: Rec'd by: ____________________ Date/Time Rec'd: ________________