

Include completed requisition with sample

Client Services: 800-495-9885 | labsupport@interpacediagnostics.com

*PancaGen™ Integrated molecular testing is also available. Please contact Client Services for additional information or questions.*

**1. PROCEDURE DETAILS**

COLLECTION DATE \_\_\_\_\_ TIME \_\_\_\_\_  AM  PM  
(MM/DD/YYYY) (HH:MM)

**SPECIMEN COLLECTION SETTING**

- HOSPITAL (INPATIENT): Date of Discharge \_\_\_\_\_  
(MM/DD/YYYY)
- HOSPITAL (OUTPATIENT)  NON-HOSPITAL AFFILIATED SETTING
- EUS REPORT attached

**2. SPECIMEN QUANTITIES**

*EACH VIAL MUST BE LABELED WITH SPECIMEN ID & TWO PATIENT IDENTIFIERS*

- PANCREATIC CYST FLUID  PANCREATIC DUCT FLUID
- PANCREATIC MASS  SUPERNATANT PANCREAS
- SUPERNATANT BILIARY  ERCP BILIARY
- ERCP PANCREAS  OTHER \_\_\_\_\_

- 1. SPECIMEN ID \_\_\_\_\_  
Number of tubes submitted: 1 2 3  \_\_\_\_\_
- 2. SPECIMEN ID \_\_\_\_\_  
Number of tubes submitted: 1 2 3  \_\_\_\_\_
- 3. SPECIMEN ID \_\_\_\_\_  
Number of tubes submitted: 1 2 3  \_\_\_\_\_

**SUPERNATANT MEDIA:**

- CYTOLYT  PRESERVCYT  RPMI  OTHER \_\_\_\_\_

**SUBMITTED CONTROL REQUIRED:**

- BUCCAL BRUSH or  BLOOD (EDTA, ACD-A, or ACD-B tube)

**3. TESTS REQUESTED or STORAGE**

**TESTS REQUESTED: 1 mL**

- ACCUCEA™ CPT 82378
- AMYLASE CPT 82150
- CYTOLOGY CPT 88173 - Physician signature required
- STORAGE ONLY

*WHEN FLUID TESTING IS ORDERED, INTERPACE DIAGNOSTICS WILL STORE ANY EXCESS FLUID FOR POSSIBLE FUTURE MOLECULAR TESTING UP TO 25 DAYS AFTER THE COLLECTION DATE.*

**4. SIGNATURE**

- I hereby authorize review of this patient's results by an Interpace Diagnostics representative for potential discussion with me, the ordering physician.

I hereby certify that the request for the above test for which reimbursement from Medicare, or third-party payors, will be sought is reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition. I also authorize providing this patient's test results to the patient's third-party payor. I certify that the patient or referring physician has given consent to the test I have ordered.

SIGNATURE \_\_\_\_\_  
(Physician signature required for Cytology)

ORDER DATE \_\_\_\_\_ PRINT NAME \_\_\_\_\_  
(MM/DD/YYYY)

**5. PATIENT INFORMATION (may adhere patient label)**

PATIENT NAME \_\_\_\_\_  
(Last Name, First, MI)

DATE OF BIRTH \_\_\_\_\_ SEX:  FEMALE  MALE  
(MM/DD/YYYY)

SSN or MRN \_\_\_\_\_

**6. BILLING INFORMATION**

- PATIENT BILLING INFORMATION ATTACHED (Face Sheet, Photocopies of Cards, etc)

**BILL TO:**

- MEDICARE  PRIVATE INSURANCE  ORDERING INSTITUTION
- MEDICAID  PATIENT PRE-PAY (US check, cert. funds, etc.)

*INTERPACE DIAGNOSTICS WILL BILL DIRECTLY FOR COVERED PATIENTS, WHEREVER PERMITTED BY GOVERNMENT REGULATIONS, PAYER BILLING POLICIES, OR CONTRACTUAL ARRANGEMENTS. IF PATIENT OR INSURANCE INFORMATION IS NOT COMPLETED OR ATTCHED, YOUR FACILITY WILL BE BILLED.*

**7. SUBMITTING DIAGNOSIS**

**ICD CODES (REQUIRED):**

PLEASE PROVIDE ALL APPLICABLE DIAGNOSIS CODES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*THE DIAGNOSIS CODE(S) PROVIDED SHOULD ALWAYS BE BASED UPON WHAT CAN BE SUPPORTED WITHIN THE PATIENT'S MEDICAL RECORD. TESTING CANNOT BE DONE UNLESS ICD CODE(S) ARE INCLUDED.*

**8. PROVIDER INFORMATION**

ORDERING INSTITUTION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

COLLECTING INSTITUTION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ORDERING PHYSICIAN(S): NPI TEL FAX

FAX ADD'L REPORTS TO: \_\_\_\_\_

**9. STAFF CONTACT**

STAFF CONTACT \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_