MT. SINAI HOSPITAL LABORATORY DEPARTMENT OF PATHOLOGY
MOUNT SINAI LABORATORY • MOUNT SINAI SCHOOL OF MEDICINE
1425 Madison Ave • East Building 9-55 • New York, NY 10029 • (212) 659-8156 • Fax (212) 427-2082

MOLECULAR PATHOLOGY REQUISITION

LAST NAME (PRINT)	FIRST NAME (PRINT)	DATE OF BIRTH MONTH DAY YEAR	AGE	GENDER ☐ Male ☐ Female

ADDRESS STREET	APT. #	CITY	STATE	ZIP	PHONE ( )

PATIENT SOCIAL SECURITY #	REFERRING PHYSICIAN (PRINT)	DICT CODE	DATE COLLECTED

INSURANCE BILLING INFORMATION

WHEN ORDERING TESTS FOR MEDICARE AND MEDICAID PATIENTS, PLEASE ORDER ONLY THOSE TESTS WHICH ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT.

☐ MEDICARE ☐ SELF PAY
☐ MEDICAID ☐ OTHER

Insured I.D. #

Group #

☐ OTHER COMMERCIAL INSURANCE OR HMO:

INSURANCE COMPANY/HMO NAME

INSURANCE COMPANY STREET ADDRESS

NAME OF INSURED (if other than patient)

ORDERING PHYSICIAN SIGNATURE

SPECIMEN SUBMITTED (MUST SELECT ONE):

☐ EDTA Whole Blood
☐ EDTA Bone Marrow
☐ Lymph Node
☐ Skin Biopsy
☐ Tissue Biopsy , Type: _____
☐ Other, Type: _____

Anatomic location/site: _____

☐ Paraffin block
Type: _____

Accession number: _____

An ICD-9 Code for this patient's visit is required in order to process this requisitition. ***Please specify ICD-9*** *code(s) for current visit (highest specificity) in the spaces below.*

REQUIRED FOR TESTING

PLEASE INCLUDE ICD-9 CODE

CLINICAL HISTORY & DIAGNOSIS: _____

_____

_____

ENGRAFTMENT/CHIMERISM TESTING

TRANSPLANT INFORMATION:

TRANSPLANT TYPE:

☐ Bone marrow ☐ Other_____

TRANSPLANT DATE: _____

DONOR NAME: _____

*****PLEASE NOTE*****
submit 2 sterile swabs for post-transplant patients

SAMPLE INFORMATION: PRE-TRANSPLANT

(PLEASE COLLECT AT LEAST 5ML BLOOD SAMPLE IN LAVENDER TUBE)

☐ **PRE-TRANSPLANT ANALYSIS (RECIPIENT)**
(test code: ENPR, test number: 4825)

☐ **DONOR ANALYSIS (Please provide recipient name)**
(test code: ENPR, test number: 4825)

RECIPIENT NAME:_____

SAMPLE INFORMATION: POST-TRANSPLANT

(PLEASE COLLECT AT LEAST 5ML SAMPLE IN LAVENDER TUBE)

☐ **CHIMERISM**
(test code: ENPOT, test number: 20984)
☐ Blood ☐ Bone Marrow

☐ **CHIMERISM, W/ CD3 & CD33 ENRICHMENT (2 LAVs)**
(test code: ENPOE, test number: 4838)
☐ Blood

REFERRING PHYSICIAN CONTACT INFORMATION

(Required for testing. Please Print.)

ADDRESS:_____

PHONE:_____ **FAX:**_____