MolecularMD
1341 SW Custer Dr.
Portland, OR 97219

T: 1-877-459-4979
F: 1-503-459-4976
www.molecularmd.com

MolecularMD
Better Performance. Better Decisions.

BCR-ABL TEST REQUISITION

PHYSICIAN / FACILITY / CLIENT INFORMATION

PHYSICIAN _____ UPIN _____

PHONE _____ EXT _____ FAX _____

DEPARTMENT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CONTACT PERSON _____

AUTHORIZED SIGNATURE _____

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____

DOB _____ SEX _____

PATIENT ID NUMBER _____ PATIENT PHONE _____

SSN _____

PATIENT ADDRESS _____

CITY _____ STATE _____ ZIP _____

BILLING

BILL TO: ☐ Pharma Contract ☐ Insurance ☐ Medicare ☐ Patient ☐ Other: _____
POLICY HOLDER: ☐ Patient ☐ Spouse ☐ Parent/Guardian

INSURANCE COMPANY _____ NAME OF INSURED _____

INSURANCE BILLING ADDRESS _____

POLICY NUMBER _____ GROUP NUMBER _____ PHONE NUMBER _____

ICD-9 CODE(S) _____ CYTOLOGICAL DIAGNOSIS _____ AUTHORIZATION/REFERRAL NUMBER _____

☐ SELF PAY ☐ PAYMENT ENCLOSED AMOUNT _____

CREDIT CARD ☐ MC ☐ VISA ☐ AMEX ☐ DISCOVER CARD # _____ EXP. DATE _____

CARD HOLDER NAME _____ SIGNATURE _____

Note: Provide a copy of insurance card, authorization and authorized signature

SPECIMEN INFORMATION

Collection Date: _____/_____/_____ Collection Time: _____ AM/PM

Specimen Type: ☐ Peripheral Blood ☐ Bone Marrow ☐ Other: _____

Specimen Tube: EDTA: Number _____ Volume: ☐ 2.5ml ☐ 5ml ☐ 7.5ml ☐ 10ml
PAXgene: Number _____ Volume: ☐ 2.5ml ☐ 5ml ☐ 7.5ml ☐ 10ml

Specimen collected by _____ Specimen ID number _____

Phase: ☐ Chronic ☐ Acute ☐ Blastic Diagnosis: ☐ New Diagnosis ☐ Relapse ☐ Monitoring ☐ MRD

Treatment: ☐ Untreated ☐ Gleevec® ☐ Sprycel® ☐ BMT ☐ Other: _____

TESTS

LEUKEMIA/LYMPHOMA TRANSLOCATIONS

☐ BCR-ABL RNA Quantitation (Major Breakpoint BCR b2a2,b3a2)

☐ BCR-ABL T315I Mutation (FRET) ☐ BCR-ABL Kinase Domain Mutation (Sequencing)

RESULTS

A hard copy of the results will be mailed to the requesting physician's office. If you would also like a copy faxed or emailed, please indicate below.

☐ Fax _____ ☐ Email _____

REQUESTS, PATIENT HISTORY, OR COMMENTS

Requisition form completed by _____

white copy: molecularmd yellow copy: molecularmd pink copy: physician