**Department of Pathology & Laboratory Medicine**

**New/Replacement Test Request Form**

1. Name of test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Type of specimen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Location where needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Turnaround time required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Suggested vendor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vendor contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Is this test FDA approved: \_\_\_ Yes \_\_\_ No

7. Justification:

a. Clinical indication:

b. Explain how the results will be used to improve patient care:

8. Will this test replace or supplement existing tests: \_\_\_ Yes \_\_\_ No. If yes, please describe the alternatives and

provide data comparing them with the proposed test:

9. How will the specimens be obtained (e.g. venipuncture, tissue, endoscopy, biopsy) and by whom (e.g. RN, MD,

Phlebotomist, Pathologist?)

10. What is the expected turnaround time for the test results? \_\_\_\_\_\_\_ hours or days

11. Are there any special specimen storage or transportation requirements? \_\_\_ Yes \_\_\_ No

12. Is any special consent required for the test? Special consent may be required for genetic tests or tests of heritable

conditions that would affect family members, for tests for reportable diseases, and for tests that could affect future

medical insurance coverage. \_\_\_ Yes \_\_\_ No If yes, please describe.

13. Are there external funding sources for this test? \_\_\_ Yes \_\_\_ No If yes, please identify

Are there established guidelines to steer appropriate utilization of this laboratory test? \_\_\_ Yes \_\_\_ No If yes, please **ATTACH** the guidelines. If no, please **SUBMIT** proposed guidelines for appropriate use of this test.

14. Do you have experience using this test? \_\_\_ Yes \_\_\_ No If yes, in how many patients?

15. What influenced your decision to request this test?

\_\_\_ Poor experience with existing test \_\_\_ Sales representative came to the department

\_\_\_ Colleague \_\_\_ Literature \_\_\_ Trade Show \_\_\_ Other (specify)

16. Have you ever, or are you currently, conducting research for the vendor or manufacturer of this test? \_\_\_ Yes \_\_\_ No

17. **Please attach any detailed price proposals from the vendor.**

**18. Please attach the manufacturer’s specifications, sales literature and a representative’s business card.**

19. Additional comments:

**B. Utilization and Reimbursement Information:**

Please provide the anticipated annual test volume: \_\_\_ In patient \_\_\_ Out patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CPT code(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-9 code(s)

Are the anticipated volumes likely to change? If so, how?

**Please attach supporting documentation that can assist the Department in its review of this test.**

Name of Physician requesting test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Return the completed form to the attention of Dr. David Gray, Department of Pathology & Laboratory Medicine**

**FOR LABORATORY USE ONLY**

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommendation:

Approved/Disapproved:

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

Signature Print Name