



UCSF Clinical Cancer Genomics Laboratory (CCGL)
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 Fax: (415) 502-2773
CCGL@ucsf.edu (please send email confirmation of orders)

UCSF 500 Cancer Gene Panel Requisition Form					Ordering Date:
<p>This test sequences the full coding region of ~480 cancer genes, and requires two specimens: tumor specimen (>25% neoplastic cells), normal (non-lesional) specimen. For testing of UCSF Pathology/Cytology cases, please load requisition and patient consent forms into APeX scanned clin docs and send by email to CCGL@ucsf.edu. For testing of outside (non-UCSF) tumor specimens, please mail requisition, patient consent and specimens to the address above.</p> <p><input type="checkbox"/> I have reviewed the "Informed Consent for UCSF500" slide set on consenting (can be requested from CCGL@ucsf.edu)</p> <p><input type="checkbox"/> A normal specimen has been collected (include specimen information below)</p>					
_PATIENT INFORMATION					
Last name:	First name:	Middle initial:	Date of Birth:	Medical Record Number:	Patient Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient Street Address, City, State, Zip code:					
_ORDERING PROVIDER INFORMATION					
Office/Practice/Institution Name:	Ordering Provider Name:	NPI #:	Provider phone no.:		
			Provider fax no.:		
Practice Street Address, City, State, Zip code:					
_MEDICAL INDICATION FOR TEST ORDER					
Diagnosis:				ICD10 Code(s) required for medical necessity:	
Treatment prior to specimen collection:					
Reason for ordering the test:					
Any history of transplantation?: <input type="checkbox"/> Yes		Date of transplant:		Tissue site:	
_SPECIMEN INFORMATION					
TUMOR	Pathology Case #:	Primary Tumor Site:	Specimen Site: <input type="checkbox"/> Primary <input type="checkbox"/> Metastasis	Diagnosis:	
NORMAL	Specimen Type: <input type="checkbox"/> Blood <input type="checkbox"/> Buccal swab <input type="checkbox"/> Skin biopsy <input type="checkbox"/> N/A (Tumor Only)	Collection date:	<i>(Please include patient's address if requesting CCGL to send out buccal swab kit.)</i>		
_BILLING INFORMATION					
_(CPT CODE: 81479 & G0452)					
INTERNAL (UCSF) (CHECK ONE BOX)	<input type="checkbox"/> UCSF outpatient within 30 days of outpatient procedure or UCSF inpatient within 14 days of inpatient discharge	<input type="checkbox"/> Insurance Authorization required and approved <input type="checkbox"/> No Insurance Authorization required	<input type="checkbox"/> Institutional Billing Phone #: _____ Address: _____	<input type="checkbox"/> Self-pay confirmed with patient <i>Please request current pricing</i>	<input type="checkbox"/> Research account, please provide ZZ #: _____
EXTERNAL (OUTSIDE INSTITUTION)	<input type="checkbox"/> Self-pay confirmed with patient <i>Please request current pricing</i>		<input type="checkbox"/> Institutional Billing Phone #: _____ Address: _____		
Complete the entire requisition to ensure prompt processing of test. Incomplete requisitions will not be processed, and will be placed on hold.					