

SHADED AREAS FOR PATIENT INFORMATION REQUIRED

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|--|--|---------------------------|--------------|----|
| PATIENT LAST NAME | | FIRST NAME | | MI |
| DOB | GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | PT. ID# / ADDITIONAL INFO | | |
| SSN | BILL <input type="checkbox"/> OFFICE/CLIENT <input type="checkbox"/> PATIENT/PATIENT INSURANCE | | | |
| PATIENT INSURANCE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD AND ATTACH COPY OF FRONT OF DRIVERS LICENSE IF UNABLE TO OBTAIN COPY OF REQUIRED INFORMATION ALL FIELDS BELOW ARE REQUIRED | | | | |
| GUARANTOR NAME/DOB (REQUIRED IF PATIENT IS A MINOR) | | | PHONE NUMBER | |
| ADDRESS | CITY | STATE | ZIP | |
| PRIMARY INSURANCE <input type="checkbox"/> MEDICARE IN-PATIENT <input type="checkbox"/> MEDICARE OUT-PATIENT <input type="checkbox"/> MEDICAID <input type="checkbox"/> INSURANCE | | | | |
| POLICY ID# | | GROUP ID# | | |
| INSURANCE COMPANY | | | PHONE NUMBER | |
| INSURANCE COMPANY ADDRESS | CITY | STATE | ZIP | |
| EFFECTIVE DATE / / | | | | |
| DIAGNOSIS / MEDICAL NECESSITY (ENTER ALL THAT APPLIES) | | | | |
| ICD-9/10 #1 | ICD-9/10 #2 | ICD-9/10 #3 | | |
| NOTICE: WHEN ORDERING TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT RATHER THAN FOR SCREENING PURPOSES. FOR MORE INFORMATION SEE reglab.org/billingcompliance/ | | | | |

Accession #: _____

Date Rec'd: ___/___/___ # of Slides: _____

Collection Date ___/___/___ Collection Time _____ **AM**
PM

PHYSICIAN PROVIDER: _____
(Indicate the Supervising Dr./P.A. or N. Pract.)

Account Number: _____

Account Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

SECONDARY / TERTIARY INS – ATTACH INFORMATION

ABN ATTACHED PRIOR AUTHORIZATION ATTACHED

MOLECULAR DIAGNOSTIC TESTING

NOTICE: Additional reference laboratory testing may be required at the discretion of the pathologist to establish or confirm a diagnosis. If additional testing is needed the client or patient may receive an invoice for additional testing from the reference laboratory. Check the box if additional reference laboratory testing is not desired. Please note that a definitive diagnosis may not be possible.

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| <p>CLINICAL INFORMATION</p> <p>SOURCE: <input type="checkbox"/> BLOOD <input type="checkbox"/> BONE MARROW <input type="checkbox"/> TISSUE _____ <input type="checkbox"/> OTHER _____</p> <p>REASON FOR REFERRAL</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>COMMENTS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Attach all relevant clinical history, pathology/cytology report(s) and other applicable test reports.</p> | <p>Pharmacogenomics</p> <p><input type="checkbox"/> Abacavir Sensitivity Genotyping (HLA B*57:01) <input type="checkbox"/> Allopurinol B*58:01 <input type="checkbox"/> Carbamazepine Sensitivity Genotyping HLA B*15:02 (Asian) and A*31:01 (European)</p> <p>HLA Genotyping for Disease Association</p> <p><input type="checkbox"/> Ankylosing Spondylitis B*27 <input type="checkbox"/> Autoimmune Hepatitis (Type I) <input type="checkbox"/> Autoimmune Thyroid Disease (AITD) DRB1*03 and DRB1*05 <input type="checkbox"/> Behcet's B*51 <input type="checkbox"/> Birdshot Chorioretinopathy A29 <input type="checkbox"/> Celiac Disease DQ2, DQ8 <input type="checkbox"/> HLA Disease Association <input type="checkbox"/> Myelodysplastic Syndrome (MDS) DRB1*15 <input type="checkbox"/> Narcolepsy DQB1*06:02 <input type="checkbox"/> Psoriatic Arthritis C*06 <input type="checkbox"/> Rheumatoid Arthritis DRB1 <input type="checkbox"/> Sjogren Syndrome <input type="checkbox"/> Systemic Lupus Erythematosus (SLE) DRB1*15:01 and *03:01 <input type="checkbox"/> Vogt-Koyanagi-Harada Syndrome (VKHS) DRB1*04:05</p> | <p>Hematopoietic Stem Cell (HSC) Transplant</p> <p><input type="checkbox"/> Chimerism, Post Transplant <input type="checkbox"/> Chimerism, Summary Report <input type="checkbox"/> DNA Frozen Cell Prep <input type="checkbox"/> HLA Antibody Single Antigen, Class I <input type="checkbox"/> HLA Antibody Single Antigen, Class II <input type="checkbox"/> HLA DNA Extract and Hold (for future testing) <input type="checkbox"/> HLA HSC Flow Crossmatch Transplant Donor (ordered on donor) <input type="checkbox"/> HLA HSC Flow T & B Lymphocyte Crossmatch (ordered on recipient) <input type="checkbox"/> HLA HSC Recipient Donors Summary Report <input type="checkbox"/> HLA HSC Related Verification Type, High Resolution <input type="checkbox"/> HLA HSC Verification Type (ordered on recipient) <input type="checkbox"/> HLA Type HSC Recipient, High Resolution <input type="checkbox"/> HLA Type HSC Related Donor Initial Type <input type="checkbox"/> HLA Type HSC Unrelated Donor (ordered on recipient)</p> <p>HLA Solid Organ Transplant</p> <p><input type="checkbox"/> Crossmatch Transplant Donor <input type="checkbox"/> DSA Summary Report <input type="checkbox"/> HLA Antibody Special Request <input type="checkbox"/> HLA Antibody Testing <input type="checkbox"/> HLA CDC T & B Cell Crossmatch (recipient) <input type="checkbox"/> HLA Virtual Crossmatch <input type="checkbox"/> Post Transplant Donor Specific Antibodies <input type="checkbox"/> Solid Organ HLA Flow T & B Lymphocyte Crossmatch (recipient) <input type="checkbox"/> Solid Organ Living Donor HLA Type <input type="checkbox"/> Solid Organ Recipient New Evaluation <input type="checkbox"/> Solid Organ Recipient Re-Evaluation</p> | <p>Inherited Disease Testing</p> <p><input type="checkbox"/> Alpha-1 Antitrypsin Mutation (Z and S Mutations) <input type="checkbox"/> Hemochromatosis Mutation (p.C282Y, p.H63D) <input type="checkbox"/> Factor II Mutation (Prothrombin g.20210G>A) <input type="checkbox"/> Factor V Mutation (Leiden p.R506Q) <input type="checkbox"/> Factor II/IV Mutations (Prothrombin g.20210G>A/Leiden p.R506Q) <input type="checkbox"/> Fragile X Mutation (FMR 1)</p> <p>Infectious Disease Testing</p> <p><input type="checkbox"/> Adenovirus DNA Detection, Qualitative <input type="checkbox"/> BK Virus DNA Detection, Qualitative (Tissue) <input type="checkbox"/> CMV DNA Detection, Qualitative <input type="checkbox"/> EBV DNA Detection, Qualitative <input type="checkbox"/> Enterovirus RNA Detection <input type="checkbox"/> HCV Genotyping <input type="checkbox"/> HSV DNA Detection <input type="checkbox"/> Parvovirus DNA Detection <input type="checkbox"/> VZV DNA Detection</p> |
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Testing Supplies

Regional Pathology Services furnishes specimen-collection supplies for use by clients that send tests to us.

Supplies are ordered online at reglab.org/customer-service/supply-orders/ testing supplies and log-on information may be obtained by calling Client Services
Toll Free 800-334-0459
Phone 402-559-6420

Courier Services

Regional Pathology Services offers an extensive courier network, which includes contracted land and air courier services. Contracted land specimen pickup is provided at no charge for specimens tested by Regional Pathology Services or our designated reference laboratories.

To inquire about scheduled stops and after hours courier service, call
Client Services Toll Free 800-334-0459
Phone 402-559-6420

If shipping specimens address to:
Regional Pathology Services
University of Nebraska Medical Center
668 S 41st St., MSB 3500
Omaha, NE 68105-1180

Transport Instructions: Specimen Handling/Shipping

To ensure the safety of personnel and the community, proper handling of specimens for shipment is mandatory. Specimens will be rejected if submitted improperly. The shipper is responsible for the proper packaging and shipping of all specimens. Shippers must be trained and certified by their employer to be able to prepare and ship packages containing diagnostic specimens, biological substances and infectious substances. Rules of the various agencies involved may differ, and may change regularly. Specimen must have at least two patient identifiers and be packaged in sealed plastic bags to prevent leakage or contamination. Place accompanying paperwork in the bag pocket, away from the specimen. Practice universal blood and body fluid precautions when handling specimens.

For tests that require scheduling or special arrangements prior to specimen collection, refer to the Online Test Menu at reglab.org for more information.

Questions?

Contact client services at 800-334-0459