DIACARTA

CAP ACCREDITED COLLEGE of AMERICAN PATHOLOGISTS

CLIA ID#: 05D2110800
Doc Number: Lab 28

RadTox™ Test Requisition Form

PART 1. PATIENT INFORMATION (REQUIRED)

Last Name | First Name | Middle Initial | Date of Birth (MM/DD/YYYY)

Street Address | City | State | Zip Code

Contact Phone Number | Email Address

Gender ☐ Male ☐ Female ☐ Other

PART 2. DIAGNOSIS AND SPECIMEN COLLECTION INFORMATION (REQUIRED)

Cancer Diagnosis and Stage | ☐ Primary Site

ICD-10 Code ☐ Z51.0 Encounter for antineoplastic radiation therapy ☐ Z51.1 Encounter for antineoplastic chemotherapy and immunotherapy ☐ T66 Radiation sickness, unspecified
☐ Others

Type of Therapy (Rx) ☐ Radiation ☐ Chemo ☐ Immuno-therapy ☐ Others

Timing of Specimen Collection vs. Therapy
☐ Pre-Rx (Baseline) ☐ Post-Rx ________ days

Sample Collection Date (MM/DD/YYYY) | Sample Collection Time (HH/MM) | Sample Collected By

PART 3. ORDERING PHYSICIAN (OR OTHER LICENSED MEDICAL PROFESSIONAL) (REQUIRED)

Last Name | First Name

Middle Initial | Physician's NPI Number | Phone Number

Email Address

Medical Professional Consent

My signature constitutes a Certification of Medical Necessity, and I hereby authorize and order DiaCarta, Inc. to perform testing for this patient as indicated on this requisition, I have reviewed the medical consent on this form and will provide test interpretation to the patient as appropriate.

Signature | Date

PART 4. PATIENT INSURANCE INFORMATION (REQUIRED)

Where applicable please include a photocopy of insurance card(s) (both sides); for Credit Card please include a photocopy of a valid credit card (both sides).

Please Select a Billing Option & Complete the Information below

☐ Medicare ☐ Medicaid ☐ Insurance ☐ Credit Card ☐ Workers Comp/Auto/LOP ☐ Information Attached

Primary Insurance Carrier | Primary Insurance ID No. | Primary Insurance Group No.

PATIENT RELATIONSHIP TO INSURED
☐ Self ☐ Spouse ☐ Dependent ☐ Other

Secondary Insurance Carrier | Secondary Insurance ID No. | Secondary Insurance Group No.

PATIENT RELATIONSHIP TO INSURED
☐ Self ☐ Spouse ☐ Dependent ☐ Other

PART 5. PATIENT CONSENT (REQUIRED)

I ______________________________ (Patient or legal guardian name), request and authorize the DiaCarta Clinical Laboratory to perform the requested test(s) for the person(s) listed above. I acknowledge the benefits, risks, and limitations outlined below. I understand that my specimen(s) will be submitted to DiaCarta for the purpose of lab testing. I authorize DiaCarta to store my specimen in case additional testing is necessary. The DiaCarta Clinical Laboratory does not return patient samples. I can request additional tests or send out samples to other institutions if there is enough sample. Once my test result has been released, remaining samples may be de-identified to be used for laboratory quality control or research. I can withdraw my consent at any time by calling the DiaCarta laboratory at (800) 246-8878. **DiaCarta will bill my insurance plan, however, should my insurance plan determine the test is not covered by my insurance plan, DiaCarta Lab offers no surprise billing and provides a Patient Financial Assistance Program.**

My signature below indicates that I have read the above information. All my questions have been answered and my inquiries regarding the purpose of this test have been discussed and fully understood by me.

Patient Name (Print) | Patient Signature

Date

AFFIX SPECIMEN BARCODE HERE