siParadigm diagnostic informatics

USA 888-599-5227 / 201-599-9044
201-599-9066
888-890-4774 (Toll-free fax)
PR 888-782-5430
866-369-4114

Requisition Number _____ Pick-up Confirmation # _____

IMMUNOHISTOCHEMISTRY AND SPECIAL STAIN REQUISITION FORM

PATIENT INFORMATION (REQUIRED)

Name _____ , _____ , _____
LAST FIRST MIDDLE

Date of Birth ____/____/____ (mm dd yyyy) Street _____

City _____ State _____ ZIP _____ (5 DIGITS)

MRN/Pt. ID/SSN # _____ Phone # _____

Gender Identity: ☐ Male ☐ Female

Ethnicity: ☐ African-American ☐ Jewish-Ashkenazi ☐ Adopted ☐ Asian
☐ Caucasian/NW European ☐ Jewish-Sephardic ☐ Native American
☐ Hispanic or Latino ☐ Middle Eastern ☐ Unknown ☐ Asked but Unknown
☐ Non-Hispanic or Non-Latino ☐ Other _____
☐ Choose not to disclose

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Unknown
☐ Asked but Unknown ☐ Other _____
☐ Choose not to disclose

PHYSICIAN INFORMATION (REQUIRED)

Referring MD _____

Attending/Ordering MD _____

Account Information _____

Next appointment date ____/____/____

CLINICAL/SPECIMEN INFORMATION (REQUIRED)

Collection date ____/____/____ (mm dd yyyy) Time _____ ☐ AM ☐ PM

Fixative ☐ **10% Neutral Buffered Formalin** ☐ Other _____

Body Site/Description _____

Specimen ID#(s) _____ ☐ See Previous Case History

☐ Paraffin Block(s)(#)
☐ Choose Best Block (Default)
☐ Other (#)
☐ Stained Slides (#)
☐ Unstained Slides (#)
☐ Perform Test on All Blocks

Diagnosis/Clinical Data _____

All Diagnosis should be provided by the ordering physician or an authorized designee.
Diagnosis/Signs/Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required)

BILLING INFORMATION (BOTH SIDES REQUIRED)

☐ Insurance
☐ Client
☐ Patient

SPECIMEN COLLECTION LOCATION
☐ Non-hospital/office patient
☐ Out-patient hospital
☐ In-patient hospital Discharge Date ____/____/____ (mm dd yyyy)
☐ Independent ambulatory clinic/surgical center

ICD-10 CODE (REQUIRED)

Notes: _____

Please attach an Advance Beneficiary Notice (ABN) for all Medicare patients (Form can be downloaded from www.siparadigm.com)

Attach clinical notes, patient information, CBC, and insurance card

LIST OF INDIVIDUAL TESTS (REQUIRED)

See website www.siparadigm.com/compendium/ for detailed panel content

☐ IHC stain - Technical Component only (slides) ☐ IHC stain with Virtual Image - Technical Component only ☐ IHC Stain with Manual Interpretation

☐ Actin (muscle specific)
☐ Actin Smooth Muscle (SMA)
☐ ADH-5
☐ ALK D5F33 (FDA)
☐ ALK-1 (FDA)
☐ Alpha-1 Fetoprotein
☐ Amyloid
☐ Annexin A1
☐ Arginase
☐ B72.3/TAG-72
☐ Bcl-1 (Cycin-D1)
☐ Bcl-2
☐ Bcl-6
☐ BerEP4
☐ Beta HCG
☐ Beta-Catenin
☐ Bg8
☐ Bob.1
☐ BRAF (FDA)
☐ CA 125
☐ CA19-9
☐ Caldesmon
☐ Calponin
☐ Calretinin monoclonal
☐ CAM 5.2/CK8&18
☐ CD1a
☐ CD2
☐ CD3
☐ CD4
☐ CD5
☐ CD7
☐ CD8
☐ CD10
☐ CD15
☐ CD19
☐ CD20
☐ CD21
☐ CD23

☐ CD25
☐ CD30
☐ CD31
☐ CD34
☐ CD43
☐ CD45 (LCA)
☐ CD56
☐ CD57
☐ CD61
☐ CD68
☐ CD71
☐ CD79A
☐ CD99
☐ CD103
☐ CD117 (C-KIT)
☐ CD138
☐ CD163
☐ CDX2
☐ CEA, monoclonal
☐ CEA, polyclonal
☐ Chromagranin A
☐ CK 5/6
☐ CK7
☐ CK17
☐ CK19
☐ CK20
☐ CK903 (34βE12)
☐ CLDN18 (FDA)
☐ cMET (FDA)
☐ CMV
☐ C-Myc
☐ D2-40 (Podoplanin)
☐ Desmin
☐ DOG-1
☐ E-Cadherin
☐ EBER (FDA)
☐ EMA
☐ Estrogen Receptor (ER)

☐ Folate receptor alpha (FOLR1/FRA) (FDA)
☐ FVIII (von Willebrand)
☐ FXIIIa
☐ Gastrin
☐ GATA3
☐ GCDFP-15
☐ GFAP
☐ GlycophorinA
☐ Glypican-3
☐ Granzyme B
☐ H. pylori ☐ Red or ☐ Brown
☐ HBME-1
☐ Hepatocyte (HepParl)
☐ HER-2/Neu (FDA)
☐ HHV-8
☐ HMB45 ☐ Red or ☐ Brown
☐ HNFI-1 BETA
☐ HPV-6/11 TAT: 7 days
☐ HPV-16/18 TAT: 7 days
☐ HPV-31/33 TAT: 7 days
☐ HSV type I
☐ HSV type II
☐ IgA
☐ IgG
☐ IgG4
☐ IgM
☐ Inhibin
☐ INSM1
☐ Kappa ISH (FDA)
☐ Kappa light chain
☐ Ki-67
☐ Lambda ISH (FDA)
☐ Lambda light chain
☐ LEF1
☐ Lysozyme
☐ Mammaglobin
☐ Melan-A (MART-1) ☐ Red or ☐ Brown

☐ **MMR Panel:**
☐ MLH-1 (FDA)
☐ MSH-2 (FDA)
☐ MSH-6 (FDA)
☐ PMS-2 (FDA)

☐ MITF-1
☐ MOC-31
☐ MUM1
☐ Myeloperoxidase
☐ Napsin
☐ NKX3.1
☐ NSE
☐ Oct-2
☐ Oct-4
☐ P120 Catinin
☐ P16
☐ P40
☐ P504s
☐ P53
☐ P57
☐ P63
☐ PAX-5
☐ PAX-8
☐ PCK, AE1/AE3
☐ PD-1
☐ PD-L1 22c3 (FDA) TAT: 48 hours
☐ PD-L1 28.8 (FDA) TAT: 7 days (sendout)
☐ PD-L1 SP142 (FDA) TAT: 7 days (sendout)
☐ PD-L1 SP263 (FDA) TAT: 7 days (sendout)
☐ Progesterone Receptor (PGR)
☐ PIN-4
☐ PLAP
☐ PRAME (Red)
☐ PSA
☐ PSAP
☐ PSMA

☐ RCC
☐ S100 ☐ Red or ☐ Brown
☐ SAT B2
☐ SMMS-1 (Myosin)
☐ SOX-10 ☐ Red or ☐ Brown
☐ SOX-11
☐ STAT-6
☐ Synaptophysin
☐ TdT
☐ Thrombomodulin
☐ Thyroglobulin
☐ TIA-1
☐ Tryptase
☐ TTF-1
☐ Tyrosinase ☐ Red or ☐ Brown
☐ Uroplakin
☐ Vimentin
☐ Wilms' Tumor 1 (WT1)

☐ AFB
☐ Alcian Blue
☐ Congo Red
☐ GMS
☐ Giemsa
☐ H&E
☐ Iron
☐ PAS Diastase (PAS-D)
☐ PAS
☐ Reticulin
☐ Trichrome
☐ Wright Giemsa

☐ Other: _____

PHYSICIAN SIGNATURE (REQUIRED)

Confirmation of Informed Consent & Statement of Medical Necessity:
I affirm each of the following: 1) Testing is medically necessary for the diagnosis of a disease or syndrome. 2) The results will be used in the patient's medical management and treatment decisions. 3) The person listed as the ordering physician is authorized by law to order the test(s) requested herein.

I am certified to order the test (s) listed above, such that these test (s) are medically necessary and I have obtained informed consent for the requested test (s) when pertinent.

Signature *(**MANDATORY FOR TESTING**) _____ **Date** _____