Please fax form to 615-255-1330

2 International Plaza Drive, Suite 510
Nashville TN 37217
Phone 615-255-8880
www.insightmdx.com

For Insight Molecular Labs Use Only

Accession # _____

Date Received _____ Time Received _____

Technician Total Volume

Ordering Client Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Email (optional) _____

NPI# _____

Results:

❑ Fax _____

❑ Phone _____

❑ Attach a copy of the Pathology Report

ADDITIONAL COMMENTS:

Patient Information - Laboratory

Name _____

Patient/Specimen I.D.# _____

Social Security # _____

Date of Birth _____ Age _____ Sex **M / F**

Date of Collection _____

Tumor Content (if known) _____

Primary Tumor Site _____

Specimen Type _____

ICD-9 Diagnosis *(must be provided)* _____

BLOCK RETURN ADDRESS IF NOT ON PATH REPORT:

Address must be provided for block return. Insight Molecular Labs is not responsible for block storage beyond 30 days if return is not requested.

Billing Information

❑ **Bill Client Directly** ❑ **Bill Insurance**
Provide information below, or attach copy of insurance card (front and back) and demographic sheet

Insurance Company _____

Subscriber Name _____

Relationship to Insured: ❑ Self ❑ Spouse ❑ Other _____

ID# _____ Group # _____

Insurance Co. Address _____

City _____ State _____ Zip Code _____

Insurance Co. Phone _____

Patient Social Security # _____

Patient Address _____

City _____ State _____ Zip Code _____

Patient Home Phone _____

Patient Work Phone _____

Frequently Requested Assays

For additional testing needs, please call Client Services

719 ❑ **EGFR Mutation Detection** DNA by Real-time PCR (Qualitative)

Ordering Physician or Non-Physician Practitioner Certification

Print Name _____ Signature _____ Date ___/____/_____

Does this patient give consent to the use of his/her sample for research? ❑ Yes ❑ No Consent is implied if a box is not marked.