

Please fax form to 615-255-1330

2 International Plaza Drive, Suite 510  
Nashville TN 37217  
Phone 615-255-8880  
[www.insightmdx.com](http://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 (include TNBC status)

ADDITIONAL COMMENTS:

**Patient Information - Laboratory**

Name \_\_\_\_\_  
Patient/Specimen I.D.# \_\_\_\_\_  
Social Security # (optional) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F    
Date of Collection \_\_\_\_\_  
Tumor Content (if known) \_\_\_\_\_  
Primary Tumor Site \_\_\_\_\_  
Specimen Type \_\_\_\_\_  
ICD-10 Diagnosis code (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     Medicare In-Patient     Medicare Out-Patient  
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. Claims Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Insurance Co. Phone \_\_\_\_\_

Patient Social Security # (optional) \_\_\_\_\_  
Patient Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Patient Home Phone \_\_\_\_\_  
Patient Work Phone \_\_\_\_\_

**Indicate Requested Assay**

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.