Diagnostic Service Line

New Test Request Form

Date: ______________________

Requesting Physician or APP: ____

Clinician Contact: Phone# ___________________ Email: __________________

TEST NAME: ____

Specimen Type (e.g. blood, other fluid, tissue –fresh/fixed): ______________________

Suggested Reference Lab: ____

Supporting Documentation – To be completed by the requesting clinician (attach relevant information where applicable)

1. Clinical Justification (Diagnostic, Prognostic, Predictive for Therapy – disease, patient criteria and selection, clinically accepted vs. investigational, current and/or in-house test).

2. Is this test standard of care?

3. How will treatment be altered based on the test?

4. What is the current best alternative to this new test?

5. Anticipated volume:
   - Number of patients per year
   - Frequency per patient
   - Inpatient vs. Outpatient mix

6. Turnaround time requirements

7. Notes/Comments (attach if necessary):

Conflict of Interest Statement: Do you or your practice have proprietary interest in, or receive remuneration from, the company or products requested? ( ) Yes - detail, ( ) No

Signature of requesting physician ____

1/16/2023