

## REQUISITION FORM

Fax (323) 224-3096

Fax Completed Form, Patient Insurance materials & Pathology Report to this number.

### 1. ORDERING PHYSICIAN INFORMATION

Name	Practice Name		
Address	UPIN		
City	State/Province	Zip Code	Country
Phone	FAX		
E-Mail			

### 2. PATIENT INFORMATION

Last Name	First Name	MI	SSN
Address			
City	State/Province	Zip Code	Country
Phone	FAX		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Birth date	/ /

### 3. PATHOLOGY SPECIMEN REQUEST

Attach Copies of Pathology Report or Fill in the Following

Pathology Dept.	Phone	FAX
Specimen Block ID/Patient Pathology #		
Patient's Medical Record #	Collection Date	/ /

Primary Cancer  Colon 153.9  Lung 162.9  Gastric 151.9  GE Junction 150.9

CHECK HERE - If specimen has been sent to Response Genetics.

IF SPECIMEN HAS NOT BEEN SENT - Response Genetics will request it.

### 4. BILLING INFORMATION

Attach Copies of Insurance Cards (Front and Back)

<input type="checkbox"/> Bill Medicare	Medicare Number
Medicare only - Hospital status when sample collected.	
<input type="checkbox"/> Hospital Inpatient	<input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Non-Hospital Patient
<input type="checkbox"/> Bill Medicaid	Medicaid Number

<input type="checkbox"/> Bill Client	Specify Group to be Billed
<input type="checkbox"/> Bill Insurance	<input type="checkbox"/> Primary Insurance <input type="checkbox"/> Secondary Insurance
Company Name	
Address	

### 5. TESTS ORDERED (PCR/RT-PCR)

#### ResponseDX: Lung™

ALL MARKERS - ERCC1, RRM1, KRAS Mutation, and EGFR Expression/Mutation, TS

INDIVIDUAL MARKERS  ERCC1  RRM1  KRAS Mutation  
 TS  EGFR Mutation  EGFR Expression

#### ResponseDX: Colon™

ALL MARKERS - ERCC1, TS, and KRAS Mutation, EGFR Expression, BRAF

INDIVIDUAL MARKERS  ERCC1  TS  KRAS Mutation  
 BRAF Mutation  EGFR Expression

#### ResponseDX: Gastric™ (Includes GE Junction)

ALL MARKERS - ERCC1, TS, and HER2

INDIVIDUAL MARKERS  ERCC1  TS  HER2

#### ResponseDX™: All Tumor Types

KRAS Mutation  BRAF Mutation  EGFR Mutation

Tumor Type \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

Bill Insurance  Secondary Insurance \_\_\_\_\_ Company Name \_\_\_\_\_

Address \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

### 6. PHYSICIAN CERTIFICATION

I hereby request and authorize Response Genetics to utilize the above information to process the tumor specimen for the indicated patient. I certify that I have obtained informed consent from the patient or his/her legally authorized representative in accordance with applicable laws including applicable genetic testing laws. I further certify that I will use and disclose the test results only as permitted by law.

SIGNATURE OF ORDERING PHYSICIAN

X

DATE

PRINT NAME