

QUICK REFERENCE GUIDE

Instructions for Completing a Test Requisition

- 1. Client Identification: This section is pre-populated with your information. To request more requisitions, contact your CSI representative, email us at clientservice@csilaboratories.com or call us at 800-459-1185.
- Patient Identification: Required all fields must be completed. MRN: Medical Record Number.
- **3.** Insurance / Billing Information: Required Provide face sheet and front/back of patient's insurance card. You must specify at least one Bill To option:
 - <u>Client Bill:</u> All charges billed to client listed in client identification section.
 - <u>Insurance:</u> All charges billed to insurance (except when payer follows CMS guidelines and patient status indicated as inpatient or outpatient; if so, TC charges billed to client, PC charges to insurance).
 - <u>Patient/Self Pay:</u> All charges billed to patient.
 - <u>Split Bill: Client (TC) and Insurance (PC):</u> All TC charges billed to client listed in client identification section, all PC charges to insurance.
 - <u>OP Molecular to Medicare:</u> Molecular testing billed to Medicare, all other testing to client (listed in client identification section).
 - <u>Bill charges to other Hospital/Facility:</u> If an entity other than who is listed in the Client Information section (#1 above) is to be billed, provide the Account Name and Account Number. Contact CSI with any questions.
- **4. Specimen Information: Required** Specimen ID, Dates/Times (collection, discharge), specimen type and prep method. Only provide information for the specimen type submitted. Note that specimen requirements are listed on the back of each requisition.
- **5.** Clinical Information: Required Diagnosis code/ICD codes, reason for referral, stage or disease status. Attach copy of lab results (i.e. CBC or pathology reports), when appropriate. Information in this section is important to support faster turn-around-time and assist our pathologists in the assessment of the case.
- **6.** Laboratory Test Requested: Required Select requested tests, including the appropriate level of service on FLOW and FISH tests. Note that tech-only tests are only available for authorized accounts. Unauthorized accounts will automatically be accessioned as global. Contact CSI to set-up tech-only authorization.
- **7.** Additional Tests, Comments or Differential Diagnosis: Include additional tests, comments or differential diagnoses that may assist our pathologists in their assessment.
- **8. Signature:** Signature is **required for orders of cytogenetic testing** that include products of conception and/or constitutional analysis. By signing, the ordering physician confirms that the patient has been informed and provided consent for testing.

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P: 1-800-459-1185 7	809-9071				Date packag	ged:
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	Gender: M	F DOB:		Age: MRN:		
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	Ordering Physici		- RECHIRED: Place	Treating Physician:e include face sheet and front/back of patie	ent's insurance car	rd.
		when specimen collected				on-Hospital Outreach / Clinic P
	Bill to: C	lient Bill Insurance	e Patient/S	elf Pay Split Bill: Client (TC) and Ins	urance (PC)	
	В	Bill charges to other hospita	al/facility:			
	Prior Authorizat			Account	Name & C-Number	
SPECIMEN INFORMATION (T	l'wo unique identifiers are re	equired on requisition & specin	men)			
Specimen ID:		Block	ID:	Collection Date:	Time:	Date of Discharge:
Bone Marrow asp	Na-Heparin	EDTA		Body Site:		
Blood	Na-Heparin	EDTA	Other	nous site:		
Smears	Air-Dried	Fixed	Stained	Formalin Fixed: Yes No	Other Fixation:	
Slides	Stained	Unstained	Touch Preps			
			iouch Preps			
	Body Fluid (specify type):					
Paraffin Block(s):		Pick Best Block:		<u>. </u>		
CLINICAL INFORMATION	PLEASE PROVIDE CE	3C		New Diagnosis Relaps	se Remis	sion
IDC-10 Code(s):				Abnormal Previous Cytogenetics / F	FISH (Provide Repor	rt) Bone Marrow Transpla
(ICD-10 information is required)			THERAPY Currer	nt Therapy	Prior (>1 month ago)
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