

Georgia Esoteric and Molecular Diagnostic Laboratories, LLC

Medical College of Georgia

1120 15th street, BF-258, Augusta, GA 30912

Tel: (706) 721-5116 Fax: (706) 721-5117

For GEM Labs USE only:

Date Received: _____

Sample Type: _____

Other: _____

PATIENT INFORMATION**Name (Last, First, MI)**

Address:

City, State, Zip:

Sex: **Male** **Female****DOB:****Phone:****SS #:****REFERRING PHYSICIAN/INSTITUTION****Name:****Hospital/Institution:**

Address:

City, State, Zip:

Name & Phone of person completing requisition:

Phone:

Fax:

E-mail:

Sign: _____

BILLING INFORMATION**Please complete all the information asked in this section, the referring physician or referring institution would be billed if needed information were incomplete.*

Bill:	Patient	Insurance	Referring Institution	Check/Money Order enclosed for \$
Relation:	Spouse	Self	Dependant	

ICD9 Codes: **Please provide all diagnosis codes applicable for tests medically necessary for that diagnosis and treatment of patient:**Please fill out any of the selected option describe below:***Credit Card Information:****Name (as appears on Card):****Account #:****Exp. Date:****Referring Institution or Physician:**

Name:

Hospital/Institution:

Address:

City, State, Zip:

Account #:**Phone:****Fax:****Insurance/Medicare/Medicaid Information:** **Please provide a copy of the front and back of the patient's insurance card (Required)*

Name:

Relationship to Patient:

Insurance Name:

Insurance Address:

Group Plan #

DOB:

Authorization #:

Insurance Phone #

City, State, Zip :

SSN#:

Gender: **M** **F****Policy ID #****Medicare or Medicaid ID #***I authorize any holder of medical information about me to release to any insurance carrier any information needed for this claim. I permit a copy of this authorization to be used in place of the original and request that the payment of medical insurance is paid to Georgia Esoteric and molecular Diagnostic Labs LLC. I also understand that I will be held responsible for any portion of the claim that the insurance company does not pay.*

Sign: _____

Date: _____

SAMPLE INFORMATION

Blood

Tissue

Urine

Other (Please Specify)

Paraffin Section

Collection Date: _____

Sample Stored at: _____

MOLECULAR CYTOGENETICS TESTS**INDICATION FOR STUDY** _____**TEST REQUESTED**PathVysionTM for Breast Cancer (2071)UroVysionTM for Bladder Cancer (2211)

PTEN (FISH) (2161)

1p36/1q25 (FISH) (2162)

19p13/19q13 (FISH) (2171)

EGFR Gene Amplification (FISH) (2051)

Genomic Microarray Analysis (2131)*

DNA Extraction (2041)

*** Please call prior to ordering**