



Patient Information

Patient Legal Name: (Last, First, MI), Sex, Date of Birth, and Medical Record#

Specimen Information

Provide information only for the specimen type that is being submitted. All orders submitted Required: Specimen ID, Date (collection, retrieved, discharge), specimen type and prep method

For more information, visit
<https://siparadigm.com/physician-support/specimen-requirements>

Clinical Information / Patient History

Accurate diagnosis information helps inform health insurance coverage and supports faster turn-around-time by preventing followup from our Client Services, Billing and Pathology groups.

To prevent a delay in patient care and to avoid billing issues, include:

Required: Diagnosis Code/ICD Code, Reason for Referral, Stage or Disease Status.

Attachments: Supplementary test results may assist our pathologists in their assessment of the case. Scan and include with submission. Utilizing online ordering will make this process easier. For more information or to order online, visit our siPortal: <https://siportal.diam.com/account/>

Test Authorization and Physician Signature

Required: Important information to support the testing is medical necessary for the patient's condition, which supports claim payment for both clients and siParadigm.

Client Information

Referring MD/ Ordering Physician: Signature and Date. Name (Last, First), NPI #

Account Number: If you do not know or do not have an account number, siParadigm will create and/or enter it when we receive the order.

Billing Information

READ CAREFULLY TO PREVENT A DELAY IN RECEIVING RESULTS. Patients may qualify for prompt pay discounts, payment plans, or financial assistance adjustments to reduce or eliminate a patient's out-of-pocket responsibility.

The siParadigm billing process is as follows: when a test order is received and testing is performed, siParadigm sends a claim to insurance to ensure the best level of coverage.


For more information on siParadigm's multiple options to reduce a patient's financial burden, and financial assistance details for underinsured and uninsured patients, please visit: <https://siparadigm.com/patient-support/billing-info>

For any questions, please contact our dedicated billing customer service representatives to discuss your options in detail. We are here to help you.

Phone: 888-599-5227 - Billing option
Email: fap.billing@siparadigm.com

How to Fill Out our Requisition Form

Issued JAN 2023


siParadigm
 Diagnostic Informatics

TEL 888-782-5430
 TEL 866-369-4114

TEL 888-599-5227 / 201-599-9044
 TEL 201-599-9066
 TEL 888-890-4774 (Toll-free fax)

Registration Number:

Your Specimen Number

Pick-up Confirmation #

☐ STAT/RUSH

☐ Call Results

☐ Need Results by: ____/____/____

HEMATOPATHOLOGY TEST REQUISITION FORM


PATIENT INFORMATION (REQUIRED)

Name _____	
Date of Birth ____/____/____	
Street _____	
City _____	State _____ ZIP _____
MRN / Patient ID# _____	Phone # _____

SPECIMEN INFORMATION (REQUIRED)

Collection date ____/____/____	Time : <input type="checkbox"/> AM <input type="checkbox"/> PM
Sent date ____/____/____	Discharge date ____/____/____
<input type="checkbox"/> CBC results attached (required for Blood and Bone Marrow)	
<input type="checkbox"/> Bone Marrow, [tube(s)] (#) _____ <input type="checkbox"/> Fresh Tissue/Fluid, [tube(s)] (#) _____ <input type="checkbox"/> Formalin Container(s) (#) _____ <input type="checkbox"/> Other Container(s) (#) _____	<input type="checkbox"/> Peripheral Blood, [tube(s)] (#) _____ <input type="checkbox"/> Slide(s) _____ <input type="checkbox"/> Paraffin Block (s) (#) _____ <input type="checkbox"/> Other (#) _____ Specify: _____
siParadigm is not responsible for any difference in quality of specimen if it is not indicated	

CLINICAL INFORMATION (REQUIRED)

ICD-10 @ Attach clinical notes, patient information, CBC, and insurance card (REQUIRED) I am certified to order the test(s) listed below, such that these test(s) are medically necessary and I have obtained informed consent for the requested test(s) when pertinent. Authorized Signature: _____ Date: _____	
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LEVEL OF SERVICE (REQUIRED)

<input type="checkbox"/> siPortfolio <small>Complete Consult Hematopathologist selects clinically pertinent tests including Histology, Flow, FISH, Karyo, Immunohistochemistry & Molecular based on patient diagnosis and preceding test results</small>	<input type="checkbox"/> Perform marked test(s) only <small>Results with interpretation</small>	<input type="checkbox"/> Technical only <small>Results without interpretation</small>	<input type="checkbox"/> Consult	<input type="checkbox"/> Call us to discuss appropriate testing
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STAGE OF DISEASE (REQUIRED)

<input type="checkbox"/> New Diagnosis	<input type="checkbox"/> Staging Evaluation	<input type="checkbox"/> Remission	<input type="checkbox"/> Relapse	<input type="checkbox"/> Measurable Residual Disease (MRD)	<input type="checkbox"/> Follow-up/Monitoring
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LIST OF DISEASES & FINDINGS

DISEASES	FINDINGS
<input type="checkbox"/> ALL (□ MRD) <input type="checkbox"/> AML <input type="checkbox"/> CLL (□ MRD) <input type="checkbox"/> CML Follow-up <input type="checkbox"/> CML New diagnosis <input type="checkbox"/> LPD <input type="checkbox"/> Lymphoma, Hodgkin <input type="checkbox"/> Lymphoma, non-Hodgkin <input type="checkbox"/> Marrow infiltration <input type="checkbox"/> MDS <input type="checkbox"/> MGUS <input type="checkbox"/> MPN <input type="checkbox"/> Myeloma (□ MRD) <input type="checkbox"/> PNH <input type="checkbox"/> Other: _____	<input type="checkbox"/> Anemia <input type="checkbox"/> Eosinophilia <input type="checkbox"/> Erythrocytosis <input type="checkbox"/> Leukocytes, Atypical <input type="checkbox"/> Leukocytes <input type="checkbox"/> Lymphopenia <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> CML <input type="checkbox"/> Eosinophilia <input type="checkbox"/> Lymphocytosis <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Thrombocytosis

LIST OF INDIVIDUAL TESTS (See complete menu on back of requisition)

MORPHOLOGY <input type="checkbox"/> siPortfolio-MORPHOLOGY	CYTOGENETICS <input type="checkbox"/> siPortfolio-CYTO
<input type="checkbox"/> Perform CBC <input type="checkbox"/> Peripheral smear review <input type="checkbox"/> Bone marrow histopathology <input type="checkbox"/> Bone marrow aspirate morphology <input type="checkbox"/> IHC/CISH <input type="checkbox"/> Special stains Specify: _____	Karyotyping <input type="checkbox"/> Myeloid <input type="checkbox"/> Myeloid (<2 days) <input type="checkbox"/> Lymphoid <input type="checkbox"/> T-Cell (>3 days) <input type="checkbox"/> B-Cell (>5 days) FISH <input type="checkbox"/> ALL <input type="checkbox"/> AML <input type="checkbox"/> CLL <input type="checkbox"/> CML <input type="checkbox"/> Eosinophilia <input type="checkbox"/> LPD <input type="checkbox"/> MDS <input type="checkbox"/> MPN <input type="checkbox"/> Myeloma <input type="checkbox"/> Lymphoma <input type="checkbox"/> Burkitt <input type="checkbox"/> DLBCL <input type="checkbox"/> Follicular <input type="checkbox"/> Mantle <input type="checkbox"/> Waldenström <input type="checkbox"/> Other: _____
FLOW CYTOMETRY <input type="checkbox"/> siPortfolio-FLOW <input type="checkbox"/> Acute Leukemia <input type="checkbox"/> ALL (□ MRD) <input type="checkbox"/> AML <input type="checkbox"/> CLL (□ MRD) <input type="checkbox"/> Hairy Cell Leukemia <input type="checkbox"/> UGL (T/NK) <input type="checkbox"/> LPD <input type="checkbox"/> LPL (Waldenström) <input type="checkbox"/> MDS <input type="checkbox"/> MPN <input type="checkbox"/> Myeloma (□ MRD) <input type="checkbox"/> Pancytopenia <input type="checkbox"/> PNH <input type="checkbox"/> Other: _____	MOLECULAR <input type="checkbox"/> siPortfolio-MOLECULAR <input type="checkbox"/> Multi-Gene NGS Panel (<65 genes) <input type="checkbox"/> Pan-Myeloid Multigene Panel (DNA & RNA) <input type="checkbox"/> Pan-Lymphoid Multigene Panel <div style="display: flex; justify-content: space-between;"> <div> • AML • CML • CMML • CNL • ET • Other: _____ </div> <div> • JMML • MDS • MPN • P. vera • PMF </div> <div> • CLL • Hairy cell • Mantle • Waldenström • B-Lymphoma, other </div> </div>

Individual Genes (See complete list of individual genes on the back)

<input type="checkbox"/> ABL Kinase Mutation (CML) <input type="checkbox"/> B-cell Gene rearrangement <input type="checkbox"/> BCR-ABL, Major (CML) <input type="checkbox"/> BCR-ABL, Minor (ALL) <input type="checkbox"/> BRAF (HCL) <input type="checkbox"/> CALR <input type="checkbox"/> CSF3R <input type="checkbox"/> FLT3 ITD & TCD by PCR <input type="checkbox"/> IDH1/IDH2 <input type="checkbox"/> IGHV hypermutation <input type="checkbox"/> JAK2 Exon 12 <input type="checkbox"/> JAK2 Exons 13 & 15 <input type="checkbox"/> JAK2 V617F <input type="checkbox"/> KIT D816X <input type="checkbox"/> MPL <input type="checkbox"/> MYD88 (WM) <input type="checkbox"/> NPM1 <input type="checkbox"/> PM1-RARA, Quant. <input type="checkbox"/> SF3B1 <input type="checkbox"/> T-cell Gene rearrangement <input type="checkbox"/> TCRB and TCRG <input type="checkbox"/> TCRG reflex to TCRB <input type="checkbox"/> TP53 <input type="checkbox"/> Other: _____

CML/MPN Reflexes

<input type="checkbox"/> JAK2 V617F : <input type="checkbox"/> BCR-ABL Major Quantitative :	<input type="checkbox"/> Reflex to Exons 12, 13 & 15 <input type="checkbox"/> Reflex to CALR & MPL <input type="checkbox"/> Reflex to CALR, MPL & >65 Gene NGS Panel <input type="checkbox"/> Reflex to Minor <input type="checkbox"/> Reflex to ABL-Kinase Mutation
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Level of Service:

- **siPortfolio Complete Consult:** Hematopathologist selects clinically pertinent tests including Histology, Flow Cytometry, FISH, Chromosomal Karyotyping, Immunohistochemistry and Molecular testing, based on patient's diagnosis and preceding test results.
- **Perform marked test(s) only:** Results with interpretation
- **Technical Only:** Results without interpretation
- **Consult**
- **Call us to discuss appropriate testing**