2001 Webber St. Sarasota, FL 34239; www.sarapath.com

REQUEST FOR ADDITIONAL TESTING - REFERENCE LAB

SaraPath Internal Use Only	Request Processed By:
Date Sendout Test(s) Req'd	Date Signed Request Received:
List any requester instructions below:	

**Reference Lab:
Please fax a copy of test results to (941) 362-8971

Submit Request Form:
by clicking submit below or fax to (941) 362-8944; Call (941) 362-8917 if there are any questions

_____ as the ordering provider, has requested that SaraPath Diagnostics send slides, blocks and/or records to your facility for laboratory testing. SaraPath Diagnostics is not requesting this service and is not responsible for the associated charges. Original slides and blocks are the custodial property of SaraPath and are irreplaceable. Do not forward or release original slides or blocks to another party or dispose of materials without the written consent of SaraPath Diagnostics. Original patient slides and blocks must be returned to SaraPath at the above address within 30 days via a traceable carrier, unless SaraPath is notified in writing.

PATIENT INFORMATION

Patient Name (Last Name, First, M.I.):
Patient Sex: ☐ Male ☐ Female
Date of Service (MM/DD/YYYY):
Parent or Guardian if Patient is a Minor (Last Name, First):
Patient Date of Birth (MM/DD/YYYY):
Patient Social Security Number:
Patient Street Address:
Patient Home Phone Number:
Patient Cell Phone Number:
Patient City, State:
Patient Zip Code:
Patient Fax Number:
Patient's Insurance Provider Name (enter "attached" if insurance info sent separately):
Policy Holder Name (if different):
Date of Birth of Policy Holder:
Insurance Provider Address:
Group Number:
Insurance Policy Number:
Insurance City, State:
Insuance Zip Code:
Insurance Provider Phone Number:
Copy of Insurance Card or Face Sheet Submitted/Attached?: ☐ Yes ☐ No

TREATING PHYSICIAN INFORMATION

Physician's Name:
Office Contact Name and Phone #:
Office Fax Number

REFERENCE LAB TESTS REQUESTED (check all that apply)

☐ ALK ☐ EFGR ☐ PD-L1 ☐ ROS1 | ☐ BRAF ☐ KRAS ☐ NRAS | ☐ MET ☐ RET | ☐ HPV

☐ LYNCH SYNDROME - IHC/MMR (MLH1, MSH2, MSH6, PMS2) ☐ T-CELL GENE ARRANGEMENT

Other Tests (please specify):

PATIENT MATERIALS DELIVERED TO

Name of Testing Facility (must be CLIA licensed):
Address of Testing Facility:
Contact Name and Phone #:
Instructions and Other Information:

CARRIER TRACKING INFORMATION

FedEx or UPS Tracking ID:
Date Sent:
Delivery Time (1, 2 or 3 Day):

MEDICAL MATERIALS AND RECORDS RELEASED *(TO BE COMPLETED BY SARAPATH PATHOLOGIST)*

SPECIMEN/CASE #

☐ ORIGINAL SLIDES #
☐ BLOCKS #
☐ RE-CUT SLIDES #
☐ TISSUE SPECIMEN #
☐ COPY OF PATHOLOGY REPORT
Other:

Faxed to: ( )
☐ DICTATED LETTER *(ATTACHED)*
Comments:
Name of Pathologist
Date
☐ OK to Send

EXPRESS CARRIER BILLING:

RECIPIENT RESPONSIBLE CARRIER ( ) ACCOUNT #

By signing this form, the eligible ordering provider authorizes the order for the reference lab test(s) and the release of the patient's slides, tissue blocks and pathology results. In addition, the provider understands that the patient and / or their insurance company are responsible for the charges for the services requested.

Signature of Eligible Ordering Provider
Date
Signature of Patient or Legal Representative
Date

Submit