



2340 Sutter Street, Room S151
 San Francisco, CA 94143, Box 1389
 Phone: (415) 502-3252
 Fax: (415) 502-2773

CCGL@ucsf.edu (PLEASE SEND EMAIL NOTIFICATION WHEN FAXING A REQUISITION FOR TESTING.)

Patient Name: _____
MRN#: _____
DOB (MM/DD/YY): _____ Sex: _____

UCSF Clinical Cancer Genomics Laboratory Requisition for Outside Institution

Ordering Date:		Ordering Provider:		NPI:	
Phone:	Fax:	Email:		Address:	

Specimen Information

Case:		Block:	Tissue Type:	Collection Date:
Clinical Information:				ICD10:

*ICD-10 code(s) is/are necessary for all test requests to indicate medical necessity, and for billing purposes. Complete the entire requisition to ensure prompt processing of test. Incomplete requisitions will **NOT** be processed.*

Test Menu

Interpretation of each test by a laboratory physician will automatically be performed and billed for.

<input type="checkbox"/> BRAF Mutation	<input type="checkbox"/> IDH1 Mutation	<input type="checkbox"/> FISH: 1p/19q Deletion
<input type="checkbox"/> EGFR Mutation	<input type="checkbox"/> IDH2 Mutation	<input type="checkbox"/> FISH: ALK Gene Rearrangement
<input type="checkbox"/> KRAS Mutation	<input type="checkbox"/> KIT Mutation	<input type="checkbox"/> FISH: BRAF Gene Rearrangement
<input type="checkbox"/> HRAS Mutation	<input type="checkbox"/> TERT Promoter Mutation	<input type="checkbox"/> FISH: ETV6 Gene Rearrangement
<input type="checkbox"/> NRAS Mutation	<input type="checkbox"/> Microsatellite Instability (MSI)	<input type="checkbox"/> FISH: EWSR1 Gene Rearrangement
<input type="checkbox"/> FOXL2 Mutation	<input type="checkbox"/> MLH1 Promoter Methylation	<input type="checkbox"/> FISH: HER2 Gene Amplification
<input type="checkbox"/> GNAQ Mutation	<input type="checkbox"/> FISH: MDM2 Gene Amplification	Cold ischemia time: _____ 10% neutral phosphate-buffered fixation time: _____
<input type="checkbox"/> GNA11 Mutation	<input type="checkbox"/> FISH: SS18 (SYT) Gene Rearrangement	
<input type="checkbox"/> JMML: https://genomics.ucsf.edu/content/ucsf-juvenile-myelomonocytic-leukemia-associated-exon-panel-jmml		
<input type="checkbox"/> Common Hereditary Cancer Panel: Requires signed patient consent or documentation in clinic note. Download consent form from: https://genomics.ucsf.edu/content/ucsf-common-hereditary-cancer-panel		
<input type="checkbox"/> Expanded Hereditary Cancer Panel: Download consent form from: https://genomics.ucsf.edu/content/ucsf-expanded-hereditary-cancer-panel		

If sending outside pathology materials, CCGL requires:

- 1) For mutation or other PCR testing: 5 unstained slides, at 10 microns on uncharged slides.
- 2) For FISH: 3 unstained slides per test (probe), cut at 4-5 microns on positively charged slides.
- 3) An adjacent H&E stained slide.
- 4) A copy of the pathology report.
- 5) **We only accept isolated or extracted nucleic acids that are extracted or isolated in a CLIA-certified laboratory or a laboratory meeting equivalent requirements as determined by the CAP and/or the CMS.**
- 6) PLEASE SHIP MONDAY THRU THURSDAY ONLY

Billing Information for UCSF (Check One Box)

<input type="checkbox"/> UCSF outpatient within 30 days of outpatient procedure or UCSF inpatient within 14 days of inpatient discharge.	<input type="checkbox"/> Bill patient's insurance, authorization approved <input type="checkbox"/> No authorization required	<input type="checkbox"/> Self-pay, patient informed Patient Phone: _____
--	---	---

Billing Information for outside Institution

<input type="checkbox"/> Institutional Billing Phone: _____ Address: _____	<input type="checkbox"/> Self-pay, patient informed Patient Phone: _____
---	---