New Test Request Form v 5.10.12
IU Health Department of Pathology and Laboratory Medicine (IUHDPLM)

Requesting physician(s): ___________________________________________ Specialty __________________

Phone number/ email address: _________________________________________________________________________

Test name: ________________________________________________________________________________________

Physician documentation required: (To be completed by the requesting physician)

Fax completed form to Send-Out laboratory at 317 624-8345. Please feel free to attach additional pages if the space provided is insufficient for your explanations.

1. Category of Test (select one):
   - [ ] Chemistry  [ ] Hematology  [ ] Immunology  [ ] Microbiology  [ ] Molecular  [ ] Anatomic Pathology

2. Briefly describe this test, the test methodology, and its purpose.

3. How did you find out this test? (examples: prior experience, patient request, sales representative, conference)

4. What is the evidence-based clinical justification for this test? Please attach medical literature/journal articles to support your position.

5. How will the results of this test improve patient outcome or management?

6. Describe anticipated practice changes (including changes to physician practice patterns and effect of this test on other departments).

7. What are the alternatives to the requested test?

8. What is the annual projected demand for this test (projected test volume)? : __________________
9. What is the date of FDA approval for this test? __________________

If not FDA approved, how is this test classified?  □ Research use only (RUO)  □ Investigational use only (IUO)

10. If this test is going to require coordination through the Send-out Department, what are the laboratory’s CLIA and CAP license numbers?

   CLIA#: ___________________     CAP#: ___________________

11. What are the turnaround time requirements for this test result?

   □ < 24 hrs   □ 2 – 3 days   □ 7 – 10 days   □ <30 days   □ Other (specify)

12. Will the test results need to be entered into the patient’s Cerner medical record?  □ Yes  □ No

13. Are there any unusual sample processing procedures needed for this test (Example: washed RBCs)?

   □ Yes    □ No    If yes, please attach copy of the procedure.

14. What are the shipping requirements for this specimen?

   □ Room temperature   □ Refrigerated   □ Frozen   □ Other (specify) ___________________

15. Is a similar or equivalent test available at the IUHDPLM?  □ Yes  □ No

   If yes, what is the name of the in-house test_________________________________________

   Why is this test not meeting your clinical needs?

16. Is this test available at one of IUHPL’s contracted reference laboratories or IU Agreement Labs?

   For list of agreement lab offerings, please go to
   http://www.iuhealth.net/portal/pathlab/requisitions?ContentID=/pathology-lab/requisitions/index.xml

   □ Yes   □ No

17. How is this test reimbursed?________________________________________

   What is the CPT code?__________________________________

18. Do you or your practice have a proprietary interest in any of the companies or products for this review?

   □ Yes   □ No

19. Do you (or does your practice) receive financial support from any company or competing product company involved with this review? (examples of financial support may include CME, research funding, educational programs or consulting fees)

   □ Yes   □ No

Please call the Send-Out laboratory at 317 491-6000 for any questions you may have.