



MOLECULAR DIAGNOSTICS LABORATORY

UT Health NGS Requisition

Dept. of Pathology & Lab Medicine
Room 344B, Medical School Bldg.
7703 Floyd Curl Drive
San Antonio, TX 78229-3900

STRClientServices@uthscsa.edu
(210) 567-6599
(210) 450-2243 (Fax)
<http://pathology.uthscsa.edu/str/molecular/>

Do not write in this space

MDL#

Patient First Name: _____ MI: _____ Last Name: _____ Sex: _____

DOB: _____ Stage at time of testing: _____

Ordering Facility: _____ Address: _____
Street City State Zip

Hospital/Pt ID#: _____ Diagnosis: _____

Specimen Submitted: _____ Fresh Frozen Paraffin

Specimen #: _____ Block: _____ Specimen Site: _____ Collection Date: _____

Requesting Physician (required): _____ Telephone: _____ Fax: _____

Physician Address: _____
Street City State Zip

Disease status: Metastatic: _____ Recurrent: _____ Relapsed: _____ Refractory: _____ None: _____

Primary ICD-10: _____

Clinical History: _____

Patient has received a transplant? Yes No

Please call results back to me directly (number above) Yes No

Best day/time to call (between 8AM-4PM M-F)

Tests Requested (check all that apply)

- UT Health Oncopanel NGS
- UT Health Heme Oncor DNA Panel NGS
- Other (specify) _____

Included copy of final or preliminary pathology report (required).

Has preauthorization been acquired (required)?*

*Attach documentation

Note: Specimens will not be processed without billing information

Bill Patient: _____
Address Phone

Bill Facility: _____
Facility Name and Address Patient ID#

Bill Insurance: _____
Insurance Company Name and Address

Name of Insured Policy # Group #

Patient Address Telephone # Date of Birth

Bill Research Account: _____
Principal Investigator Account #