



Indiana University Health

Department of Pathology and Laboratory Medicine

IU Health Pathology Laboratory

Indianapolis, IN 46202

## New Test Request Form **v Oct 2025**

IU Health Department of Pathology and Laboratory Medicine (IUHDPLM)

Requesting physician(s): \_\_\_\_\_ Specialty \_\_\_\_\_

\_\_\_\_\_ Specialty \_\_\_\_\_

Contact phone number: \_\_\_\_\_

Contact email address: \_\_\_\_\_

Test name: \_\_\_\_\_

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

Fax completed form to Send-Out laboratory at 317-968-1211 or email to [msandbakken@iuhealth.org](mailto:msandbakken@iuhealth.org). 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 when you submit this request.**

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. When was 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)  
 Laboratory developed test

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? \_\_\_\_\_

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 or viability time limits for this test (e.g. washed RBCs)?

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

14. What are the shipping requirements for this specimen?

- Room temperature  
 Refrigerated  
 Frozen  
 Other (specify) \_\_\_\_\_

15. Is a similar or equivalent test already 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 are the CPT codes? \_\_\_\_\_

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

Signatures of submitting physicians: \_\_\_\_\_  
\_\_\_\_\_

**\*\*\*Please be advised – if testing is approved for clinical use there will be at least 4 to 6 month period prior to any specimens being collected and shipped for testing. This time is utilized to finalize the contract agreement with the reference laboratory, have the test built by the laboratory LIS team and establish proper billing parameters.\*\*\***

Please call the Send-Out Laboratory Reference Coordinator at 317 491-6853 or email [msandbakken@iuhealth.org](mailto:msandbakken@iuhealth.org) with any questions you may have.

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***Sendouts department use only***

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Testing has been approved for clinical use

Testing has NOT been approved for clinical use

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Signature of Send Out  
Medical Director

Printed Name

Date