Indiana University Health

Department of Pathology and Laboratory Medicine
IU Health Pathology Laboratory
Indianapolis, IN 46202

New Test Request Form v 10/4/2018

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 317-968-1211 or email to ppederse@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.

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 ☐ N0

Please call the Send-Out Laboratory Reference Coordinator at 317 491-6851 or email ppederse@iuhealth.org with any questions you may have.

Signature **Printed Name** **Date**

Testing has been approved for clinical use

****Please be advised – if testing is approved for clinical use there will be a 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.****

Signature **Printed Name** **Date**

Testing has NOT been approved for clinical use