KNIGHT CANCER INSTITUTE
Oregon Health & Science University
KNIGHT DIAGNOSTIC LABORATORIES

Laboratory Shipping Address: 2525 SW 3rd. Avenue
Suite 350 Portland, OR 97201
Correspondence Address: 3181 SW Sam Jackson Park Road
Mailstop MP-350 Portland, OR 97239
Phone: 855-KDL-1LAB (535-1522) - Fax: 855-KDL-1FAX (535-1329)

# FAX TRANSMISSION

Date: 04/12/12

To: Brandi or Dr. Csanky

From: Sho Newman

Company / Facility: St. Luke's Clinic

Department: Knight Diagnostic Labs

Phone: 208-814-8300

Phone: 503-494-5400

Fax: 208-733-8970

Fax: 503-494-7645

Number of Pages (Including Cover Sheet): 2

---

Comments:

Requisition form from MSI. Please call Sho at Knight Diagnostic Lab for instructions! Thanks!

KNIGHT CANCER INSTITUTE
Oregon Health & Science University
KNIGHT DIAGNOSTIC LABORATORIES

**Laboratory Shipping Address:** 2525 SW 3rd. Avenue
Suite 350 Portland, OR 97201
**Correspondence Address:** 3181 SW Sam Jackson Park Road
Mailstop MP-350 Portland, OR 97239
**Phone: 855-KDL-1LAB (535-1522) - Fax: 855-KDL-1FAX (535-1329)**

# Microsatellite Instability Test Requisition

| Patient Information | | Client Information | |
|---|---|---|---|
| Name (Last, First, MI): | | Ordering Physician Name: | |
| Address: | | Ordering Physician NPI: | |
| City, State, Zip: | | Office/Facility Name: | |
| Patient Phone: | Fax: | Client Address: | |
| Patient DOB: | Sex: | City, State, Zip: | |
| Patient ID/MRN #: | | Client Phone: | Fax: |
| Notes: | | Account #: | |

## Additional Physicians To Receive Report Copy

| | | |
|---|---|---|
| CC Physician Name: | CC Physician Phone: | Fax: |
| CC Physician Name: | CC Physician Phone: | Fax: |

## Billing Information

☐ Bill Insurance (Please Attach Copy of Insurance Card or Billing Face Sheet) ☐ Bill Client (Invoice will be sent to Client Address Listed Above) ☐ Bill Patient

Primary Insurance Company Name: _____ Group # _____ Policy# _____

☐ Medicaid ☐ Medicare (If Medicare denies payment, patient agrees to be personally responsible for charges.) Signature:_____

Relation to Insured : ☐ Self ☐ Child ☐ Spouse ☐ Other _____

Secondary Insurance Company Name: _____ Group # _____ Policy# _____

☐ Medicaid ☐ Medicare (If Medicare denies payment, patient agrees to be personally responsible for charges.) Signature:_____

Relation to Insured : ☐ Self ☐ Child ☐ Spouse ☐ Other _____

## Clinical Information

| | |
|---|---|
| Specimen Type: ☐ Peripheral Blood ☐ DNA<br>☐ Paraffin Block ☐ Unstained Slides | ICD-9/ Clinical Diagnosis: (See Concurrent Case In Powerpath)<br>Date of Specimen Collection: |
| Diagnosis and Organ: ☐ Primary ☐ Recurrence ☐ Metastasis | Specimen Source:<br>External Pathology Institution Name: |
| **For Internal Cases Only** | Pathology Phone: Fax: |
| OHSU Block ID: | Outside Pathology Block ID: |
| Normal: | Normal: |
| Tumor: | Tumor: |
| % Tumor in Marked Area: | % Tumor in Marked Area: |

## Test Ordered

| Test Code | Test Name |
|---|---|
| ☐ 5000 | Microsatellite Instability (MSI), PCR |