

 <p>4883 Medical Dr., Suite 4077, San Antonio, TX 78229 T: 210-593-2514 F: 210-949-0261</p>	 <p>DATE AND TIME RECEIVED <small>(For CMDX Use Only)</small></p>	<p>10-255</p> <p>*Ship Samples to: CMDX Client Services, 310 Goddard, Suite 100, Irvine, CA 92618 T) 800-710-0624 F) 949-753-4725</p>
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1. Patient Information

Last Name		First	Middle	SSN
Street Address			City, State Zip	
Telephone #	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Medical Record Number (MRN)

2. Billing/Insurance Information

<input type="checkbox"/> Ordering Institution		<input type="checkbox"/> 3rd party (Insurance) - Attach copy of card		<input type="checkbox"/> Self-Pay - Attach Payment Options form	
Please complete billing information below and enclose copies of insurance information . Complete billing information must be provided or ordering institution may be billed.				Authorization Number <small>(For CMDX use only)</small>	
<input type="checkbox"/> Insurance	Carrier:	Member ID#	Group#:		
Address:		City, State Zip			
Insured Name:		SSN:	Relationship to patient:		

3. Ordering Institution Information

Institution Name		Address	
GenomeConsult at The START Center		4383 Medical Dr., Suite 4077, San Antonio, TX 78229	
Phone	210-593-2514	Fax	210-949-0261
Contact Name	Shelly Gunn, M.D., Ph.D.	Email	shelly.gunn@stoh.com
Phone	210-593-2514	Secure Fax	210-949-0261

4. Physician Information - Reports will be sent to physicians listed below at fax # provided.

Ordering Physician		Referring Physician		Fax Additional Reports to:	
Shelly Gunn, M.D., Ph.D.					
Specialty	Pathology	NPI#	Specialty	NPI#	Specialty
Phone	(201) 593 - 2514	Phone		Phone	()
Fax	(201) 949 - 0261	Fax		Fax	()

5. Specimen Information

Specimen ID#	# of Samples	Yes, diagnostic pathology report enclosed- # of pages_____
DNA	FFPE Tissue Block	FFPE Tissue Block plus H&E stain slide
Fresh Tissue	FFPE Slides (# ____, thickness ____)	
Frozen Tissue	FFPE Shaves (# ____, thickness ____)	
Sample Description/Source of Tissue:		Results of IHC Studies: ER status _____ PR status _____ HER2 status _____
Collection Date:	Collection Time:	Patient previously treated? <input type="checkbox"/> Yes <input type="checkbox"/> No

6. Clinical Information- Please enclose diagnostic pathology report

CMDX Test Menu	CPT Codes
HemeScan®	83891(x2), 88386(x6)
Her17Scan™- Chromosome 17/HER2 Evaluation	83891(x2), 88386(x6)
HerScan™- Global genomic evaluation and subtyping	83891(x2), 88386(x6)
OncoScan™	83891(x2), 88386(x6)
Germline Genome Analysis	83891(x2), 88386(x6)
Clinical Pathology Consultation	80502(x1)

7. CMDX Test Menu CMDX accepts specimens Monday-Saturday, 8am-5pm PST

Technical Only Program (TOP)

8. Level of Service

9. Comment Section (Special Requests/Questions)

10. Required Signature

By my signature below, I certify that the above-ordered molecular analysis is reasonable and medically necessary for the diagnosis, care and treatment of the this patient's condition.

Signature	Print Name	Date
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Note: Please enclose any diagnostic pathology reports.

-- Patient, Billing/Insurance, and Ordering/Physician information are requested for timely processing of the specimen submitted. --