DCISionRT®

DCIS TEST REQUISITION FORM

Fax 888.909.DCIS (3247)
Phone: 888.211.DCIS

PRELUDEDX™
26051 Merit Circle, Suite 103
Laguna Hills, CA 92653

I. SUBMISSION STATUS

○ First Submission ○ PreludeDx to request specimen from Pathology ○ Resubmission ○ Ordering Physician to request specimen from Pathology

II. DCISionRT TEST ORDER

Non-Linear Risk Assessment DCIS Test (7) IHC Biomarkers with or without computer assistance and consult to confirm diagnosis

○ DCISionRT performed post breast conserving surgery

○ DCISionRT performed on pre-surgical core biopsy
(Results assume negative margins. Lesion extent ≤1cm)

MUST COMPLETE SECTION BELOW AND ATTACH PATHOLOGY REPORT

Patient Age at DCIS Dx:____years **Palpable:** ○ Yes ○ No ○ Unknown

Surgical Margin: ○ Positive ○ 1mm ○ 2mm ○ 3mm ○ 4mm or greater
(Pre-surgical assumes negative margins)

Tumor Size:_____mm
(For pre-surgical specimen: provide imaging size estimate)

III. SPECIMEN INFORMATION

Collection Date:_____

Biopsy Type: ○ Excisional ○ Core Needle

Site of DCIS: ○ Right Breast ○ Left Breast ○ Breast, NOS

IV. SUBMITTING DIAGNOSIS

Submitting Diagnosis:_____

Provide as many ICD-10 diagnosis codes as necessary: ○ Other:_____

○ D05.1 ○ D05.10 ○ D05.11 ○ D05.12 ○ D05.8 ○ D05.80
○ D05.81 ○ D05.82 ○ D05.9 ○ D05.90 ○ D05.91 ○ D05.92

V. CLIENT INFORMATION

Account Details

Ordering Physician Name (Name will appear on report)

Contact Name

Contact Phone Contact Fax

Contact Email

Additional Physician Report Recipient (Email or Fax)

VI. PHYSICIAN AUTHORIZATION

THIS SECTION IS MANDATORY FOR THIS ORDER TO BE VALID

I represent that I am treating this patient as the physician of record and authorizing the performance of the test(s) identified on this Order. I have concluded that the test(s) I am ordering is medically necessary for treatment of this patient because I anticipate that this test(s) will provide prognostic and/or predictive information which has not been obtained already. This Order form is part of the medical record, is consistent with other entries in the record and accurately describes the reason(s) I am ordering the test(s).

Printed Name

Signature of Ordering Physician Date

Registry Study #:_____

VII. PATIENT INFORMATION

Patient Name: Last, First, Middle

Address

City State Zip Country

Date of Birth (MM/DD/YYYY) Patient Phone Social Security Number

Gender: ○ Female ○ Male MRN:_____

Note: PreludeDx DCISionRT is not validated for men

VIII. BILLING INFORMATION

COMPLETE section AND attach copy of face sheet and front and back of insurance card

Billing Type: ○ Private Insurance ○ Medicare ○ Patient ○ Bill Client ○ Other

Primary Insurance Name Member ID

Primary Auth # (if available) Phone

Secondary Insurance Name Member ID

Relationship to insured: ○ Self (skip section) ○ Spouse ○ Dependent

○ Other: Insured DOB (MM/DD/YYYY)_____ Insured SSN_____

Patient Status: ○ Hospital Outpatient ○ Non-Hospital Patient
○ Hospital Inpatient (>24hr Stay)
○ Date of Discharge:_____

IX. PATHOLOGY INFORMATION (SLIDE OR BLOCK SPECIMENS)

Facility Submitting Pathologist Name NPI

Address

City State Zip Country

Phone Fax Email

Multiple Primaries: ○ Yes ○ No ○ Choose Best ○ Other

○ Fax a Copy of Results Report to Pathology

Number of Unstained Slides:_____**(Charged slides required) OR**

Surgical Pathology Block Number:

1:_____ 2:_____

3:_____ 4:_____

CAP/ASCO Fixation Time >6 & <72 hrs: ○ Yes ○ No ○ Unknown

Neutral Buffered Formalin Fixation: ○ Yes ○ No ○ Unknown

Block Return Address: (If different than the Pathology Account listed to the left)

City State Zip Country

Phone

Place Label from Kit Box