Complete, print and submit

Reset Form

MAYO CLINIC
Mayo Medical Laboratories

Pathology Test Request Form

Client Information (required)

Client Name		
Client Account No.		
Client Phone	Client Order No.	
Address		
City	State	Zip Code

Patient Information (required)

Patient ID *(Medical Record No.)*	
Patient Name *(Last, First, Middle)*	
Gender ☐ Male ☐ Female	Birth Date *(Month DD, YYYY)*
Collection Date *(Month DD, YYYY)*	Time ☐ a.m. ☐ p.m

Submitting Provider/Provider Name Information (required)

Submitting/Referring Provider *(Last, First)*
Fill in only if Call Back is required. Phone ( ) _____ – _____ Fax* ( ) _____ – _____
Provider's National I.D. (NPI)

**Fax number given must be from a fax machine that complies with applicable HIPAA regulation.*

Specimen Types Sent

☐ Fixed Formalin	☐ Slides	Is specimen infectious? ☐ Yes ☒ No
☐ Frozen Tisue	☐ X-rays	SPECIMEN SOURCE: (ie, breast, lung, soft tissue)
☐ Gluteraldehyde	☐ Zeus Media	
☐ Paraffin Blocks	☐ Other	

Pathology Report/Clinical Notes (required)

(Include a brief history, pertinent laboratory results, suspected diagnosis, and reason for referral.)

Pathologist's Name (required)

Submitting/Referring Pathologist *(Last, First)*
Phone ( ) _____ – _____ Fax* ( ) _____ – _____

**Fax number given must be from a fax machine that complies with applicable HIPAA regulation.*

Note: It is the client's responsibility to maintain documentation of the order.

New York State Patients: Informed Consent for Genetic Testing

"I hereby confirm that informed consent has been signed by an individual legally authorized to do so and is on file with this office or the individual's provider's office."

Signature _____

Note: Test requests without a signature will not be performed.

MML Internal Use Only

Ship specimens to:

Mayo Medical Laboratories
3050 Superior Drive NW
Rochester, MN 55901

Customer Service: 855-516-8404

Visit www.MayoMedicalLaboratories.com for the most up-to-date test and shipping information.

Billing Information

- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing related questions:
800-447-6424 (US and Canada)
507-266-5490 (outside the US)

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Patient Information (required)

Patient ID *(Medical Record No.)*	Client Account No.
Patient Name *(Last, First, Middle)*	Client Order No.
Birth Date *(Month DD, YYYY)*	

To prevent delays in testing, a preliminary/final pathology report and clinical notes are required for each case submitted.
For a complete list of oncology tests, see the oncology test request form.

PATHOLOGY REQUEST

- ☐ PATHC Pathology Consultation
- ☐ CNSA Central Nervous System Consultation, Autopsy

Attention: List suggested stains/tests below. These will be included as part of the consultation if considered helpful by the consulting pathologist. Each additional test will be charged separately.
Request for stains and tests can be provided in a cover letter.

_____

_____

_____

MOLECULAR PATHOLOGY

- ☐ ARMS Alveolar Rhabdomyosarcoma by Reverse Transcriptase PCR (RT-PCR)
- ☐ MDM2F MDM2 (12q15) Amplification, Well-Differentiated Liposarcoma/Atypical Lipomatous Tumor, FISH, Tissue
- ☐ DSRCT Desmoplastic Small Round-Cell Tumor by Reverse Transcriptase PCR (RT-PCR)
- ☐ EWS Ewing Sarcoma, by Reverse Transcriptase PCR (RT-PCR)
- ☐ PDGF PDGFB (22q13), Dermatofibrosarcoma Protuberans/Giant Cell Fibroblastoma, FISH, Tissue
- ☐ SYT Synovial Sarcoma by Reverse Transcriptase PCR (RT-PCR)
- ☐ KIT8 KIT Exon 8, Mutation Analysis
- ☐ KIT9 KIT Exon 9, Mutation Analysis
- ☐ KIT11 KIT Exon 11, Mutation Analysis
- ☐ KIT13 KIT Exon 13, Mutation Analysis
- ☐ KIT17 KIT Exon 17, Mutation Analysis
- ☐ BCAT Beta-Catenin, Fibromatosis, Mutation Analysis
- ☐ FOXL2 FOXL2, Granulosa Cell Tumor, c.402C->G Mutation Analysis
- ☐ IDH IDH1/2, Mutation Analysis
- ☐ MAMLF MAML2 (11q21) Rearrangement, Mucoepidermoid Carcinoma (MEC), FISH, Tissue
- ☐ USPF USP6 (17p13), Aneurysmal Bone Cyst and Nodular Fasciitis, FISH, Tissue

RENAL BIOPSIES

- ☐ RPCWT Renal Pathology Consultation, Wet Tissue

CYTOLOGY SPECIMENS

Non-Gyn-Cytology

*Pathology report not required for Non-Gyn-Cytology tests

- ☐ FBILM Biliary Tract Malignancy-Cytology, FISH
  Specify site: _____
- ☐ FUROC UroVysion for Detection of Bladder Cancer, Urine
  Specify source: _____

THERAPEUTIC AND PROGNOSTIC MARKERS

ALL tests require a paraffin block - Use the Pathology Packaging Kit (T554)

Multi Blocks Select One:
☐ Choose Best Block ☐ Perform on All Blocks

Was specimen fixed in 10% neutral buffered formalin within 1 hour from surgical collection time?
☐ Yes ☐ No

Has specimen been fixed in 10% neutral buffered formalin for 6 to 72 hours?
☐ Yes ☐ No

Breast

- ☐ ERPR Estrogen/Progesterone Receptor, Semi-Quantitative Immunohistochemistry, Manual
- ☐ HERBA HER2, Breast, Quantitative Immunohistochemistry, Automated with HER2 FISH Reflex
- ☐ HERBN HER2, Breast, Quantitative Immunohistochemistry, Automated, No Reflex
- ☐ HERDM HER2, Breast, DCIS, Quantitative Immunohistochemistry, Manual with HER2 FISH Reflex
- ☐ HERDN HER2, Breast, DCIS, Quantitative Immunohistochemistry, Manual No Reflex
- ☐ KI67B Ki-67(MIB-1), Breast, Quantitative Immunohistochemistry, Automated

Gastrointestinal

- ☐ HERGM HER2, Gastric/Esophageal, Semi-Quantitative Immunohistochemistry, Manual
- ☐ HERGN HER2, Gastric/Esophageal, Semi-Quantitative Immunohistochemistry, Manual, No Reflex
- ☐ KINET Ki-67(MIB-1), Gastrointestinal/Pancreatic Neuroendocrine Tumors, Quantitative Immunohistochemistry, Automated

OTHER

- ☐ DEXT DermPath Consultation, Wet Tissue
- ☐ CIB Cutaneous Direct Immunofluorescence Assay (IFA), Biopsy
- ☐ EM Electron Microscopy
- ☐ MPCT Muscle Pathology Consultation
- ☐ MBCT Muscle Biopsy Consultation, Outside Slides and/or Paraffin Blocks
- ☐ NPPC Peripheral Nerve Pathology Consultation

ADDITIONAL TESTS (INDICATE TEST CODE AND NAME)

Print

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