

Test Requisition Form

Please Fax to 877-764-7628

Medical Director: Anthony Magliocco MD, FCAP

6555 Sanger Rd Suite 260, Orlando FL 32827 CLIA ID#: 10D2192649 CAP ID#: 8832145 CDPH ID#: CDS-90005103



Customer Service: 1 (754) 242 9682 or support@proteanbiodx.com

Name (Last First MI)	ation				Ordering Phy	sician	Informat	ion	
Name (Last, First, MI)					Physician Name / NPI # Fax				
DOB (MM/DD/YYYY)	Female (XX) Male (XY) Phone (primary) Other(X)				Office / Practice / Institution Physician's Email				
Street Address					Street Address				
City	State	Postal Code	Country		City	State	Postal	Code	Country
MRN (Medical Record Number)					Office Contact Name		Contact Phon	е	Contact Email
Insurance Billi	ng Infoi	rmation			Patient Billing	j Infor	mation		
rimary Insurance		Policy # Group #			Patient Name				
Primary Policy Holder		DOB			Patient Email Pa			atient Phone Number	
Secondary Insurance		Policy #	Group #		Patient Mailing Address				
Secondary Policy Holder			DOB		City	State	Postal Co	ode	Country
□ Thyroid Guidel	Px	Additional And	illary Testing	□BRAI	F □HRAS □KRAS	S □NRA	S □RET/F		☐ LERT promoter
Collection Deta	ils								
Collection Date: (MM//DD/YYYY) / / Time of					Collection:			Mark on Diagram:	
☐ Fine Needle Aspirate ☐ FFPE Block				☐ FFPE Slides # of Slides:				UPPE	ER ISTHMUS
Tumor size (cm): Specimen ID:					cimen ID:			MIDD	LE
Enlarged lymph nodes	s: Yes	Tumor size (cm T Stage:):	T Stag	or size (cm): ge:			LOW	ER
	No	N Stage:		N Sta	ge:				RIGHT LEFT
thyroid lobectomy The patient had a	ng conside /, radiofreq a thyroid lob	ered for a total thy luency ablation a bectomy. A "high	nd/or active active risk" result will be	e survei e used t	result will be used to illance. to consider a comple I to consider radioact	tion thyro	idectomy.	ative t	treatments including
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