



Population Health Services

**WELLSPAN HEALTH
New Test Request Form**

Date: _____

Requesting MD: _____

Clinician Contact: Phone# _____ Email: _____

TEST NAME: _____

Specimen Type (e.g. blood, other fluid, tissue –fresh/fixed): _____

Suggested Reference Lab: _____

Supporting Documentation – To be completed by the requesting clinician (attach relevant information where applicable)

1. Clinical Justification (Diagnostic, Prognostic, Predictive for Therapy – disease, patient criteria and selection, clinically accepted vs. investigational, current and/or in-house test).
2. How will treatment be altered based on the test?
3. What is the best alternative to this new assay?
4. Anticipated volume:
 - Number of patients per year
 - Frequency per patient
 - Inpatient vs. Outpatient mix
5. Turnaround time requirements
6. Notes/Comments (attach if necessary):

Conflict of Interest Statement: Do you or your practice have proprietary interest in, or receive remuneration from, the company or products requested? () Yes - detail, () No

Signature of requesting physician _____

2/15/2015