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 _____