New Test Request Form

WELLSPAN HEALTH
Diagnostic Service

Date: _____

Requesting Physician or APP:	
Phone #	**Email:**
TEST NAME:	
Specimen Type (e.g. blood, other fluid, tissue – fresh/fixed):	
Suggested Reference Lab (if applicable):	

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. Is this test standard of care?

3. How will treatment be altered based on the test?

4. What is the current best alternative to this new test?

5. Anticipated volume:

Number patients per year:	
Frequency per patient (hourly, daily, weekly, monthly, etc.)	
Inpatient vs. outpatient mix:	

6. Turnaround time requirements (How soon do you need the results?)

7. 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: _____