

# Thyroid GuidePx Test Requisition Form

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@proteanbiobdx.com

Please Fax to 877-764-7628

Medical Director: Anthony Magliocco MD, FCAP

Patient Information			
Name (Last, First, MI)			
DOB (MM/DD/YYYY)	<input type="checkbox"/> Female (XX) <input type="checkbox"/> Male (XY)	Phone (primary)	
<input type="checkbox"/> Other _____ (X___)			
Street Address			
City	State	Postal Code	Country
MRN (Medical Record Number)			

Ordering Physician Information			
Physician Name / NPI #			Fax
Office / Practice / Institution		Physician's Email	
Street Address			
City	State	Postal Code	Country
Office Contact Name		Contact Phone	Contact Email

Insurance Billing Information		
Primary Insurance	Policy #	Group #
Primary Policy Holder		DOB
Secondary Insurance	Policy #	Group #
Secondary Policy Holder		DOB

Patient Billing Information			
Patient Name			
Patient Email		Patient Phone Number	
Patient Mailing Address			
City	State	Postal Code	Country

Test Request		
<input type="checkbox"/> Thyroid GuidePx Qualisure	<b>Additional Ancillary Testing</b> <input type="checkbox"/> BRAF <input type="checkbox"/> ROS 1 <input type="checkbox"/> KRAS <input type="checkbox"/> NTRK1,2,3 <input type="checkbox"/> RET <input type="checkbox"/> MET <input type="checkbox"/> Gene Fusions	<b>Pathology Review:</b>  <b>Optional Tests</b> <input type="checkbox"/> Liquid Biopsy (Blood Sample) <input type="checkbox"/> Genetics (Risk MAPS™)
<input type="checkbox"/> Protean CGP 600+		

Clinical Information
<b>Patient History of Cancer:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____ <b>Family History of Thyroid Cancer:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____ <b>Previous "Indeterminate" FNA Result:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____ <b>Other Clinical History (relevant to lab test results):</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____

Collection Details		
Collection Date: (MM/DD/YYYY) ____ / ____ / ____	Time of Collection:	<b>Mark on Diagram:</b> UPPER MIDDLE LOWER 
Number of Containers:	Size of Lesion:	
<b>Thyroid:</b> <input type="checkbox"/> Right Lobe <input type="checkbox"/> Left Lobe <input type="checkbox"/> Upper Pole <input type="checkbox"/> Mild <input type="checkbox"/> Lower Pole <input type="checkbox"/> Isthmus		
Collection Type: <input type="checkbox"/> Block <input type="checkbox"/> Slides	Specimen ID #:	

Certificate of Medical Necessity, Consent, Test Authorization, and Physician Signature		
My signature is a Certificate of Medical Necessity by the treating physician that this testing has been explained and is authorized for the care of the patient and that consent has been obtained for Protean BioDiagnostics to release results as part of reimbursement, for follow up information to be obtained, and for the data to be de-identified and disclosed for quality assurance and research. Protean BioDiagnostics customer service may be contacted for any discounts if insurance does not fully cover and with any questions. Unless otherwise indicated, it is acknowledged that Protean BioDiagnostics may direct the testing selected based on the requisition and approach listed on the Protean BioDiagnostics website, according to the pathology reports, and status or quantity of the specimen received.		
Ordering Physician Signature _____	Printed Name _____	Date ( MM/DD/YYYY ) ____ / ____ / ____