Thyroid GuidePx®

Test Requisition Form

Please Fax to 877-764-7628

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

Medical Director: Anthony Magliocco MD, FCAP

PROTEAN BIODIAGNOSTICS

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

Patient Information

Name (Last, First, MI)			
DOB (MM/DD/YYYY)	☐ Female (XX) ☐ Male (XY) Other_____ (X___)	Phone (primary)	
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

☐ Thyroid GuidePx

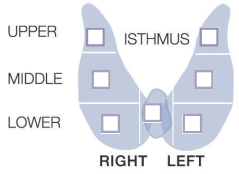
Additional Ancillary Testing ☐ BRAF ☐ HRAS ☐ KRAS ☐ NRAS ☐ RET/PTC fusion ☐ TERT promoter ☐ NTRK fusion

Collection Details

Collection Date: (MM/DD/YYYY) _____ /_____ /_____ Time of Collection:

☐ Fine Needle Aspirate	☐ FFPE Block	☐ FFPE Slides # of Slides:
Tumor size (cm):	Specimen ID:	Specimen ID:
Enlarged lymph nodes: ☐ Yes ☐ No	Tumor size (cm):	Tumor size (cm):
	T Stage:	T Stage:
	N Stage:	N Stage:

Mark on Diagram:



Clinical Utility (Check one)

☐ The patient is being considered for a total thyroidectomy. A "low risk" result will be used to select more conservative treatments including thyroid lobectomy, radiofrequency ablation and/or active active surveillance.

☐ The patient had a thyroid lobectomy. A "high risk" result will be used to consider a completion thyroidectomy.

☐ The patient had a total thyroidectomy. A "high risk" result will be used to consider radioactive iodine.

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)

Patient Consent

My signature below acknowledges and certifies that I agree to grant permission for Alio Health Services and Protean BioDiagnostics to collect and disclose my personal information to health care professionals, insurance providers or other third-parties, as needed for the Program's administration of Reimbursement Services to strict data protection and security requirements.

Patient Signature _____ Printed Name _____ _____ /_____ /_____ Date (MM/DD/YYYY)

Reimbursement Support: 1-888-526-4403, Fax: 1-866-948-2523 or Email: qualisure@aliohealth.com