SUMMIT PATHOLOGY

Add-On Request Form

Date: _____ Office: _____

Phone#:_____ Fax#:_____

Patient Name: _____ DOB: _____ Case ID: _____

Tissue Site(s) : _____ DOS: _____

Patient Status: ☐ Inpatient ☐ Outpatient ☐ Neither Discharge date:_____

Check the following Add-On test(s) appropriately as needed:

___ Her2

___ Breast Marker Panel

___ ALK by FISH

___ EGFR Gene Mutation

___ ROS1

___ PDL1

___ KRAS Gene Mutation

___ P16

___ Afirma or Thyroseq

___ MMR panel
(MLH1, MSH2, MSH6, PMS2)

___ BRAF Gene Mutation

For Add-On testing such as: **CMOCO, FoundationOne, Oncotype DX, etc.** providers must contact the respective facility directly to request testing. The facility will then reach out to Summit Pathology for the necessary materials.

___ Consultative Opinion **(at Summit Pathology)**

___ Consultative Opinion **(other)**: Please provide requested laboratory and pathologist:

_____

___Other: Please specify the test name and indicate the facility where the test should be sent below.

–_____

_____

** If the Consultation facility or Reference laboratory has a proprietary form, this may be provided to you for additional signature or data. Additionally, if prior authorization is required for testing, that must be completed by the treating physician.

Contact Person: _____

Ordering Physician (print full name): _____

Ordering Physician's Signature: _____

Please fax request to (970) 212-0541
If you have any questions, please call (970) 212-0530
Thank you for the opportunity to serve you!

Summit Pathology: 5802 Wright Drive, Loveland, CO 80538 • **Phone:** 970-212-0530 • **Toll Free:** 800-920-6227
Fax: 970-212-0553 • **Web:** www.summitpathology.com
Offices Inside: North Colorado Medical Center, Medical Center of the Rockies, McKee Medical Center, Poudre Valley Hospital, Memorial Hospital Colorado Springs and Cheyenne Regional Medical Center