



University of Pittsburgh Medical Center
Molecular & Genomic Pathology Laboratory
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(To Be Completed by MGP Staff)

Received Date

Accession #

PancreaSeq® Genomic Classifier (GC) Test Requisition Form

Pancreatic Cyst Fluid Test: 74 genes for mutations, copy number alterations, gene fusions and gene expression, NGS, and CEACAM5 (CEA) mRNA expression, qRT-PCR

PATIENT IDENTIFICATION

Last Name	First Name	M.I.	SSN/MRN
Birthdate (mm/dd/yyyy)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Diagnosis	ICD-10 Code(s)
Surgical Path/Cytology #			

CLIENT INFORMATION

Requesting Institution, Physician Name

Requesting Institution / Physician Address

Phone Number	Fax Number
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BILLING INFORMATION

Institution Responsible For Payment

Billing Address

Phone Number	Fax Number
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SPECIMEN INFORMATION

Submitted Specimen(s):

- Specimen(s) must be collected in approved vials containing MGP Preserve solution.
- Please indicate the submitted specimen type and sample collection date.
- Complete specimen detail box(es) below.
- Endoscopy or cytology report is **required** and must be submitted with specimen(s).

SUBMITTED SPECIMEN(S)	SAMPLE COLLECTION	PATIENT INFORMATION LABEL
<input type="checkbox"/> Pancreatic Cyst Fluid <input type="checkbox"/> Pancreatic Duct Fluid <input type="checkbox"/> Pancreatic Solid Mass <input type="checkbox"/> Other _____	Sample Collection Date: (mm/dd/yyyy) _____/_____/_____	Place patient information label here, if applicable. You do not need to fill out the patient information above if all information is included on label in this area.

Specimen 1:

Cyst Location: Head Neck Body Tail Duct

Cyst Size: _____ cm (greatest diameter)

Other / Comment: _____

Copy of Endoscopy or Cytology Report Required

Specimen 2:

Cyst Location: Head Neck Body Tail Duct

Cyst Size: _____ cm (greatest diameter)

Other / Comment: _____