cernostics
PROVIDING DEEPER TISSUE INSIGHTS

tissuecypher®
BARRETT'S ESOPHAGUS ASSAY

TEST REQUISITION FORM

Customer Service 412-820-3050
235 William Pitt Way Building B1 Suite 421 | Pittsburgh, PA 15238
www.cernostics.com

SPECIMEN TYPE: ☐ Esophageal Pinch Biopsy ☐ Esophageal Mucosal Resection ☐ Surgical Resection ☐ Other (specify in comments)

SPECIMEN # _____ **PART:** _____

DATE OF SERVICE (provide most recent date):

Specimen collected: _____ **OR** **Specimen obtained from storage:** _____

INITIAL PATHOLOGICAL DIAGNOSIS:
ATTACH PATHOLOGY REPORT (REQUIRED)

NUMBER OF ESOPHAGEAL LEVELS (ALSO CALLED SITES OR PARTS) SUBMITTED: _____

REASONS FOR ORDERING THE TEST/OTHER COMMENTS:

SPECIMEN SHIPMENT TRACKING# _____

PATIENT INFORMATION (REQUIRED - may add patient label)

Last Name, First Name | M.I.

Street Address

City | State | ZIP

Phone#

Date of Birth | Sex M☐ F☐

Medical Record #

BILLING INFORMATION (REQUIRED)

Bill to: ☐ Insurance - ***Attach information:*** ☐ Patient FaceSheet ☐ Medical Insurance Card (front & back) ☐ Drivers License/ID

☐ Patient (self-pay)

☐ Physician

MANAGEMENT PLAN

Prior to receiving TissueCypher® results, which surveillance and treatment options would you consider for this patient?

Endoscopic Surveillance Interval: ☐ 3 months ☐ 6 months ☐ 1 year ☐ 3 years ☐ 5 years ☐ Other (specify): _____

Treatment (check all that apply):

☐ No treatment
☐ Mucosal Resection
☐ Radiofrequency Ablation
☐ Other endoscopic therapy (specify):_____
☐ Esophagectomy
☐ Referral to oncologist
☐ Other therapy/treatment option (specify):

TEST ORDERING

TissueCypher®Barrett's Esophagus Assay ☐

Other

FOR LABORATORY USE ONLY

Date Received | Time Received

Accession ID# | Acct#

CLIENT INFORMATION (REQUIRED)

Client Name

Physician Name (Gastroenterologist) | NPI#

Physician Signature

By submitting this form the ordering physician certifies that the request for the above test for which reimbursement from Medicare, or third-party payors, will be sought is reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition, and that the referring physician or patient has given consent to the test. The physician also authorizes provision of this patient's test results to the patient's third-party payor.

Address

City | State | Zip

Email Address (for results)

Submitting Pathologist | Phone#

ICD-10 Code (REQUIRED)

☐ K22.70 BE without dysplasia
☐ K22.710 BE with low grade dysplasia
☐ K22.719 BE with dysplasia, unspecified
☐ Other: _____

Note: Please report the diagnostic code(s) that best describe the reason for performing the test

SPECIMEN REQUIREMENTS

Nine (9) positively-charged glass slides with serial sections taken at five (5) micron thickness from formalin-fixed, paraffin-embedded tissue blocks:

- That have not been treated with Bouin's reagent, eosin, methylene blue, mercurochrome or other dyes;
- That are labeled with ≥2 patient unique identifiers and serial section number;
- One of which is stained with hematoxylin and eosin according to ordering institution's standard protocol;
- The remaining eight of which are unstained;
- That are freshly prepared and shipped to Cernostics in less than 48 hours after sectioning. Ship Monday-Thursday for overnight delivery in a Cernostics collection kit to the address above;
- For patients with multiple biopsy levels taken at the same endoscopy, the biopsy with the highest diagnosis determined by a GI subspecialist pathologist should be selected for testing (low grade dysplasia > indefinite for dysplasia > non-dysplastic)
- For patients with multiple biopsy levels with the same pathologic diagnosis, the pathologist should select the biopsy block with the largest total area of intact, evaluable esophageal intestinal metaplasia for testing.

FORM SUBMISSION

Complete electronic form, submit via email to customer.service@cernostics.com, and include a printed paper copy of completed form with slide shipment.

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