New Test Request Form

Hendricks Regional Health Laboratory

Requesting Physician: ____Group:___________________

Phone number/ email address: ____

Test name: ____

Physician documentation required: (To be completed by the requesting physician)

Email completed form to lesa.nelson@hendricks.org. Please feel free to attach additional pages if the space provided is insufficient for your explanations.

1. Category of Test (select one):

☐Chemistry ☐Hematology ☐Point of Care ☐Microbiology ☐ Blood Bank ☐Anatomic Pathology

2. Briefly describe this test, the test methodology, and its purpose.

3. How did you find out about this test? (examples: prior experience, patient request, sales representative, conference)

4. What is the evidence-based clinical justification for this test? Please attach medical literature/journal articles to support your position.

5. How will the results of this test improve patient outcome or management?

6. Describe anticipated practice changes (including changes to physician practice patterns and effect of this test on other departments).

7. What are the alternatives to the requested test?

8. What is the annual projected demand for this test (projected test volume)? : ___________________

9. What is the date of FDA approval for this test? ___________________

   If not FDA approved, how is this test classified? ☐ Research use only (RUO) ☐ Investigational use only (IUO)

10. If this test is going to be sent to a non-interfaced lab, what are the laboratory's CLIA and CAP license numbers?

    CLIA#: ____________________ CAP#: __________________

11. What are the turnaround time requirements for this test result?

    ☐ < 24 hrs ☐ 2 – 3 days ☐ 7 – 10 days ☐ <30 days ☐ Other (specify)

12. Will the test results need to be entered into the patient's Epic medical record? ☐ Yes ☐ No

13. Are there any unusual sample processing procedures needed for this test?

    ☐ Yes ☐ No If **yes**, please attach copy of the procedure.

14. What are the shipping requirements for this specimen?

    ☐ Room temperature ☐ Refrigerated ☐ Frozen ☐ Other (specify) __________________

15. Is a similar or equivalent test available at HRH or IUHPL? ☐ Yes ☐ No

    If yes, what is the name of the in-house test____

    Why is this test not meeting your clinical needs?

16. Is this test available at one of HRH's contracted reference laboratories?

    ☐ YES ☐ NO

17. How is this test reimbursed?________________________________

    What is the CPT code?____________________________________

18. Do you or your practice have a proprietary interest in any of the companies or products for this review?

    ☐ Yes ☐ No

19. Do you (or does your practice) receive financial support from any company or competing product company involved with this review? (examples of financial support may include CME, research funding, educational programs or consulting fees)

☐ Yes ☐ N0

Please call Lesa Nelson at 317-745-3430 ext 11541 or email lesa.nelson@hendricks.org with any questions you may have.

Lab Signature :__________________ **Lab Printed Name:______________________** **Date:_____________**

Signature in this area indicates that test <u>HAS BEEN</u> approved for clinical use.

****Please be advised – if testing is approved for clinical use there could be a 2 - 4 month period prior to any specimens being collected and shipped for testing. This time is utilized to finalize the contract agreement with the reference laboratory, have the test built by the laboratory LIS team, and establish proper billing parameters.****

Lab Signature :__________________ **Lab Printed Name :________________________** **Date:____________**

Signature in this area indicates that test HAS NOT been approved for clinical use. See explanation below: