MYRIAD myPath® Melanoma

MYRIAD GENETIC LABORATORIES, INC.
320 Wakara Way • Salt Lake City, Utah 84108
Phone: 800-231-4442
Fax: 801-582-4000
Email: myPathMelanoma@myriad.com

TEST REQUEST FORM

TO AVOID DELAYS PLEASE COMPLETE ENTIRE FORM AND INCLUDE A PATHOLOGY REPORT

DATE OF BIOPSY

PATIENT INFORMATION (Complete information required)

Name (last, first, middle initial)	Gender ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Patient ID #	Email

Address	City	State	Zip	Cell phone	Daytime phone

ORDERING PHYSICIAN INFORMATION (Dermatopathologist)

Name (last, first)	Myriad HCP Account #	Degree	NPI #
Address	City	State	Zip

Office Contact Name	Phone	Fax	Email

TREATING PHYSICIAN INFORMATION (Dermatologist)

Name (last, first)	Myriad HCP Account #	Degree	NPI #
Address	City	State	Zip

Office Contact Name	Phone	Fax	Email

SPECIMEN INFORMATION REQUIRED

SPECIMEN TYPE: ☐ Block **OR** ☐ Slides

SAMPLE FIXATIVE: ☐ 10% Neutral buffered formalin

☐ Other (description) ______________________

SPECIMEN IDENTIFICATION NUMBER(S): ________________________

PROCEDURE TYPE: ☐ Punch Biopsy ☐ Shave Biopsy ☐ Excisional Biopsy

ANATOMICAL SITE (e.g., left ear) ______________________

TISSUE TYPE (e.g., skin): ______________________________

THIS LESION IS FAVORED TO BE: (PLEASE CHOOSE ONLY ONE)

☐ Malignant ☐ Benign ☐ Indeterminate

ICD-10 CODE: ☐ D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin

☐ Other: ______________________

DIFFERENTIAL DIAGNOSIS:

1.______________________

2.______________________

3.______________________

SAMPLE VALIDITY

Myriad myPath Melanoma has not been validated on metastatic melanomas, re-excision specimens, non-melanocytic neoplasms, or biopsies from a patient receiving immunosuppressant therapy or radiation treatment. Analysis of these samples may result in incorrect test interpretation; therefore these specimens are not suitable for testing and will be cancelled.

AUTHORIZED SIGNATURE

I hereby authorize testing and confirm that informed consent has been obtained, if required by state law. I hereby attest that the person listed in the Ordering Physician space above is authorized by law in the relevant jurisdiction to order the test(s) requested herein. To the best of my knowledge, this is a primary melanocytic lesion, NOT a metastatic melanoma, a re-excision specimen, non-melanocytic neoplasm, or a biopsy from a patient receiving immunosuppressant therapy or radiation treatment. I CERTIFY THAT THE INCLUDED LESIONS ARE SUITABLE FOR TESTING.

____
HEALTHCARE PROVIDER'S SIGNATURE DATE

INSURANCE INFORMATION

Please list the patient's insurance provider: ______________________________

Include a copy of BOTH sides of the patient's insurance card. If you submit more than one card, indicate which is primary.

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