CNSide® CSF Assay Platform: Test Requisition Form

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IMPORTANT: only patients with carcinoma are eligible for testing

***Required Field**

Test Ordered
CNSide® CSF Tumor Cell Enumeration

Specimen Requirement
2 mL Cerebrospinal Fluid (CSF)

Healthcare Provider Information
*Ordering Physician: _____ NPI #: _____
Account #: _____ Institution/Practice Name: _____
Address: _____
City: _____ State: ____ Zip/Postal Code: _____ Country: _____
Phone: _____ Email: _____

Patient Information
*Last Name: _____ *First Name: _____ Middle Initial: ___ Suffix: ___
*Address: _____
*City: _____ *State: ____ *Zip/Postal Code: _____ Country: _____
*Phone: _____ Email: _____ *Medical Record #: _____
*Birth Date (mm/dd/yyyy): _____ Sex at Birth: ___Male ___ Female

Clinical Information
*Primary Diagnosis: _____ *ICD-10 Primary Code: _____ *ICD-10 Secondary Code: _____
*Status: ___ New Diagnosis ___ Progression ___ Residual or Post-Treatment Monitoring
*Indications: ___ Diagnosis ___ Therapy Choice ___ Therapy Response ___Other (please specify): _____
*Previous CNSide® CSF Testing for this patient? ___ Yes ___ No

Specimen Collection Information
*Procedure: ___ Lumbar Puncture ___ Ommaya Draw *Collection Volume: _____
*Collection Time (00:00): _____ ___ AM ___ PM *Collection Date (mm/dd/yyyy): _____

Billing Information
*Bill To: ___ Insurance ___ Medicare ___ Patient ___ Healthcare Provider
*Patient Type: ___ Inpatient ___ Outpatient ___ Non-Hospital Patient

Note: Inpatient orders will automatically be billed to Healthcare Provider

*Required Documentation (Please Attach)
___ Copy of Insurance Card (front/back) and/or Face Sheet
___ Cytopathology Reports (most recent)
___ Surgical Pathology Reports
___ Clinical History/Progress Notes

Healthcare Provider Attestation
By signing below, you represent on behalf of the Client that, with respect to the above-requested tests, (i) the tests are medically necessary for the care/treatment of the patient; (ii) you have obtained all necessary government, third party payor, and patient consents and approvals to request CNSide Diagnostics, LLC to perform the tests and to provide CNSide Diagnostics, LLC with all necessary information; and (iii) all information provided to CNSide Diagnostics, LLC in this form is accurate and correct; (iv) should the tests be denied payment by any third party payor, the Patient will be financially responsible for the costs of such tests; and (v) should this form conflict with any terms or conditions of any agreement between the parties, this form shall control. Extra patient specimen not needed for clinical testing may be used for internal testing validation in a de-identified manner.

Physician Signature: _____ Date (mm/dd/yyyy): _____

For Internal Use Only
of Tubes: ___ Tube Type: _____
mL Received: 1 ___ 2 ___ 3 ___ 4 ___
Expiration (mm/dd/yyyy): _____
Received (initials): _____
Date (mm/dd/yyyy): _____
Comments: _____

Please email this test requisition along with other required documentation to support@CNSide-Dx.com

The CNSide® CSF Assay Platform has not been cleared or approved by the U.S. Food and Drug Administration. This test is a lab developed test and its performance characteristics determined by the CNSide Diagnostics, LLC CLIA-certified laboratory.