ThyroSeq® International

University of Pittsburgh Medical Center
Molecular & Genomic Pathology Lab T 1-412-864-6162
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(To Be Completed by MGP Staff)

Received Date **MGP #**

ThyroSeq® v3 Genomic Classifier (GC) Requisition Form

PATIENT INFORMATION

Last Name	First Name	M.I.	SSN/MRN

Birthdate	Sex ☐ M ☐ F	ICD-10 Code(s)	Cytology #

CLIENT INFORMATION

Requesting Institution/Physician

Requesting Physician Address

Phone Number	Fax Number

BILLING INFORMATION

Person/Institution Responsible For Payment

Billing Address

Phone Number	Fax Number

SPECIMEN AND DIAGNOSIS INFORMATION

SUBMITTED SPECIMEN(S)

☐ **FNA sample(s) in ThyroSeq*Preserve* solution**
☐ **FNA sample(s), fixed, cell block sections**
☐ **FNA sample(s), smears***
☐ **Tissue paraffin sections:**

*Pap and Diff-Quik stained smears are acceptable. **Pap stained smears are preferred due to higher success rate of testing.**

SAMPLE COLLECTION

Sample Collection Date:
(mm/dd/yyyy)

_ _ / _ _ / _ _ _ _

PATIENT INFORMATION LABEL

Place patient information label here, if applicable. You do not need to fill out patient information above if all information is included on label in this area.

CLINICAL INFORMATION

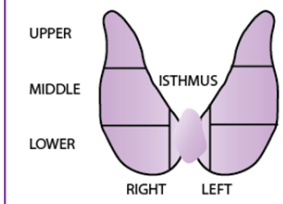
Cytology Diagnosis (Bethesda Category):
☐ Atypical/FLUS (B III)
☐ Suspicious for Follicular Neoplasm (B IV)
☐ Suspicious for Malignancy (B V)
☐ Malignant (B VI)*
☐ Insufficient for Diagnosis (B I)*
☐ Benign (B **II**)*
*Special clinical indications

Ultrasound characteristics, check all that apply:
☐ Solid
☐ Hypoechoic
☐ Irregular borders
☐ Rim Calcifications
☐ Microcalcifications
☐ Macrocalcifications
☐ Taller than wide
☐ Intranodular vascular pattern
☐ Other, specify:_____

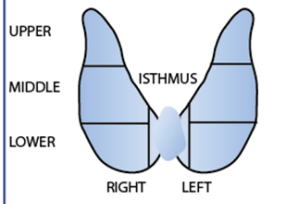
History of cancer, specify:_____

NODULES

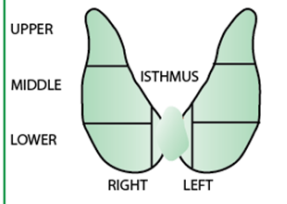
Specify nodule size and mark location for each nodule biopsied.

NODULE 1
LOCATION:_____


SIZE:_____ cm
COMMENTS:

NODULE 2
LOCATION:_____


SIZE:_____ cm
COMMENTS:

NODULE 3
LOCATION:_____


SIZE:_____ cm
COMMENTS:

CYTOLOGY REPORT INCLUDED: _____

Ordering Physician Name (Printed):_____ **Ordering Physician Signature:** _____