



**PROPATH**

A Sonic Healthcare Anatomic Pathology Practice

# Test Add-on Request Form

Fax to Client Response Center: 214-237-1731

(NO COVERSHEET REQUIRED)

Please perform the following test(s) on the case indicated below:

TEST	ICD-10
_____	(Required)
_____	(Required)
_____	(Required)

Today's Date: \_\_\_\_\_

Client Account Number: \_\_\_\_\_

ProPath Accession #: \_\_\_\_\_

Date of Collection: \_\_\_\_\_

Patient Full Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Ordering Clinician Signature: \_\_\_\_\_

I attest that I am authorized to order the test(s) and that the test(s) is medically necessary for my patient.

### CONFIDENTIALITY NOTICE

This FAX contains PRIVILEGED and CONFIDENTIAL information intended for use by the recipient above. If you are not the intended recipient of this FAX, or the employee of, or the agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination or copying of this FAX is strictly prohibited. If you have received this FAX in error, please notify the Department of Pathology at the phone number listed in the header of this FAX.

For assistance, please call the Client Response Center at 800-258-1253.