Diagnostic
Pathology
Medical
Group, Inc.

Additional Testing Authorization Form

Submit this form to order additional testing from a tissue block prepared by DPMG Histology

I authorize Diagnostic Pathology Medical Group, Inc. (DPMG) to order the following test(s) on my patient.

- ❑ HPV TYPING
- ❑ ER/PR & HER2 (IHC)
- ❑ HER2 IHC REFLEX 2+ TO FISH
- ❑ FISH ONLY
- ❑ MICROSATELLITE INSTABILITY
- ❑ OTHER ____

Patient's name:____

Date of Birth:____________ DPMG Report Number: ___________

Ordering Physician: _______________Phone Number: __________

If the test you have ordered is not performed by Diagnostic Pathology Medical Group, the tissue block will be forwarded to an outside facility along with the patient's insurance information. It is the responsibility of the ordering physician to obtain prior authorization for this service if required as part of the patient's healthcare coverage. By my signature below, I acknowledge that DPMG is not financially responsible for payment of the additional tests ordered.

Physician Signature: ______________________Date:_________

IF CONFIRMATION OF ORDER IS REQUIRED PLEASE INCLUDE YOUR FAX NUMBER FOR A FAX BACK:______________________

Please fax this form to (916) 446-9330

ORDER RECEIVED: date_______ time________ initials_________

If you have any questions please feel free to contact
DPMG Customer Service at (916) 446 – 0424

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