Penn Medicine
Hospital of the University of Pennsylvania
Department of Pathology and Laboratory Medicine
Division of Precision and Computational Diagnostics (PCD)

TEST REQUEST FORM

v1.0

This form is intended to help present the best case for new or modified tests within the PCD. The Division recognizes that not every question or example below directly applies to every proposal; however, the more information provided to the PCD, the more consideration it can give to each proposal. Please be as complete and specific as possible.

Date:

Name of requestor(s):

Department/Division(s):

Contact email(s) and phone(s):

1. Describe the test request:
    a. What disease entity or entities is the test intended for? Please provide as much specificity as possible (e.g. salivary gland carcinoma vs. pan-cancer, Influenza A virus vs. respiratory viruses, etc.).

    b. If applicable, please list specific gene names and nature of genomic alterations the test is intended for. (e.g. *ERBB2* amplification and *BRCA1* and *BRCA2* loss-of-function mutations vs. "breast cancer mutations"). Are there specific mutations you wish to test for (e.g. BRAF p.V600E)?

    c. List the specimen types likely to be sent for testing (e.g. blood, nasopharyngeal swabs, CSF, FFPE, etc.).

    d. Is the desired test result qualitative or quantitative?

    Qualitative (positive/negative result)

2. Describe the clinical utility of the requested test:
    a. Will the test aid in diagnosis, prognosis, or treatment of patients? Please cite literature references including any recommendations from professional societies supporting this testing when possible.

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b. Is there a target turn-around-time (TAT) which is required to meet the clinical utility of this test?

No

c. In what setting will the majority of testing be ordered?

Inpatients

d. Will the test require additional support outside of the laboratory (e.g. genetic counseling)? If unsure, indicate "unknown".

3. Provide information about the test volume:
   a. Currently, are you ordering this test clinically?

      No

   b. Currently, are you aware of other HUP Healthcare professionals ordering this test clinically?

      No

      Testing performed at:

   c. Are you aware of any laboratories performing this test on a research basis?

      No

   d. What is the expected number of test requests per year? If unsure, provide your best estimate or indicate "cannot determine".

   e. Can you provide any information regarding charges and reimbursement (particularly whether pre-authorization is required)?

4. Any additional comments or information that the PCD Development Team should consider not included elsewhere in the request:

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Please email the completed form to Laura.Pritchard@uphs.upenn.edu. You will be contacted by a member of the PCD Development Team regarding this request. Thank you for your interest and submission.