



## Disaccharidase & Barrett's Esophagus Requisition

|                                |                                |                                      |
|--------------------------------|--------------------------------|--------------------------------------|
| <b>Date Specimen Collected</b> | <b>Time Specimen Collected</b> | <b>STAT</b> <input type="checkbox"/> |
|--------------------------------|--------------------------------|--------------------------------------|

**Laboratory Use Only**

|                          |                          |                              |
|--------------------------|--------------------------|------------------------------|
| Accession Number         | Date Received            | Time Received                |
| Group/Practice Name      |                          | Practice Contact Information |
| Ordering Physicians      |                          | Address Line 1               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     |
|                          |                          | Address Line 2               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     |
|                          |                          | City, State Zip              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     |
|                          |                          | Phone                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     |
|                          |                          | Other                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     |
|                          |                          | Fax                          |

**Patient and Insurance Information**

\*Currently Not Accepting Medicaid or Managed Medicaid Plans - Contract Pending\*

|                   |                         |                     |                   |        |
|-------------------|-------------------------|---------------------|-------------------|--------|
| First Name        | Last Name               | MI                  | DOB               | Gender |
| Address Line 1    | Address Line 2          | City                | State             | Zip    |
| Home Phone        | Cell Phone              | Race*               | Ethnicity*        |        |
| Insured's Name    | Relationship to Patient |                     | Social Security # |        |
| Home Phone        | Cell Phone              | DOB                 | Gender            |        |
| Primary Insurance |                         | Secondary Insurance |                   |        |
| Group #           | ID#                     | Group #             | ID#               |        |
| Address           |                         | Address             |                   |        |
| City              | State                   | Zip                 | City              | State  |
|                   |                         |                     | State             | Zip    |

### Test Panels

#### Disaccharidase

Small Bowel Biopsy for Disaccharidase Testing (Maltase, Lactase, Sucrase, Palatinase)

#### Barrett's Esophagus

Barrett's Esophagus FISH Panel

#### Source

Jar 1 Pan Brushings       Jar 2 Nodular Brushings (if present)       Other \_\_\_\_\_

#### Length of Barrett's Epithelium and Descriptive Findings

#### Pathology

|   |   |
|---|---|
| <input type="checkbox"/> Anatomic Pathology _____ Jar _____ | <input type="checkbox"/> Anatomic Pathology _____ Jar _____ |
| <input type="checkbox"/> Anatomic Pathology _____ Jar _____ | <input type="checkbox"/> Anatomic Pathology _____ Jar _____ |
| <input type="checkbox"/> Anatomic Pathology _____ Jar _____ | <input type="checkbox"/> Anatomic Pathology _____ Jar _____ |

#### ICD-10 Codes

- |   |  |
|---|--|
| <input type="checkbox"/> E73.0 Congenital Lactase Deficiency    | <input type="checkbox"/> K22.70 Barrett's Esophagus without Dysplasia            |
| <input type="checkbox"/> E73.0 Other Lactose Intolerance        | <input type="checkbox"/> K22.710 Barrett's Esophagus with Low Grade Dysplasia    |
| <input type="checkbox"/> E73.9 Lactose Intolerance, Unspecified | <input type="checkbox"/> K22.711 Barrett's Esophagus with High Grade Dysplasia   |
| <input type="checkbox"/> K21.0 GERD with Esophagitis            | <input type="checkbox"/> K22.719 Barrett's Esophagus with Dysplasia, unspecified |
| <input type="checkbox"/> K21.9 GERD without Esophagitis         |  |

|   |                      |
|---|----------------------|
| Physician Signature <b>(Required for Testing)</b> | Accessioner Initials |
|   | 1 _____ 2 _____      |

\*Race and Ethnicity are required by certain states and the CDC