

REQUEST FOR NEW TEST TO BE ADDED TO SEND-OUT TEST FORMULARY

Directions: Please complete and sign this form. Fax (585) 475-0862 or email to: send-outlabseniortechs@urmc.rochester.edu

TEST NAME:

METHODOLOGY:

RECOMMENDED TESTING LAB:

Doctor:

Address:

Phone:

Please provide a detailed explanation of how the addition of this test to the send-out formulary will influence clinical management, treatment plans, and patient care.

Indicate expected volume:

Conflict of interest statement

University of Rochester Medical Center and the LDC (Laboratory Diagnostic Committee), realize that physicians may have relationships with outside manufacturing companies/laboratory vendors. Any potential conflict of interest does not disqualify any physician from requesting a laboratory test for consideration. It is, nevertheless critical for this committee to be aware if these relationships exist. Please answer the following questions around conflict of interest.

1. Do you (or your practice) have a proprietary interest in any of the companies or products for this review?
 Yes No

2. Do you (or does your practice) receive financial support from any company or competing product company involved with this review? (example; financial support may include CME, research funding, educational programs or consulting)
 Yes No

Signature of ordering physician

Date

SHADED AREAS FOR LAB USE ONLY

Performing Lab:	Test code:	NYS approved:	Price:
Specimen requirements:			Approved by LDC:
Methodology:			
			Date: