Research Biopsy Request

THIS FORM IS FOR ANY RESEARCH STUDY INVOLVING *IMAGE-GUIDED BIOPSIES*

IF IMAGING ALONE IS TO BE PERFORMED PLEASE USE THE REQUIRED IMAGING FORM

Patient Name: Requesting Physician:

MRN: Trial/Study Name:

DOB:

Study Number:

IRB Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smart Key:

Research Coordinator:

Contact info:

 Phone:

 PIC:

ICD-10 Code(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*Biopsy Target: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*\*\*\*\*\*\*

Specimen Handling: (Please check one of the following and respond to additional necessary information if indicated):

 Specimen to be picked-up by research coordinator for external shipping:

 10% formalin

 Special media to be provided by coordinator prior to biopsy

\*\*\*\*\*Amount of tissue required: (gauge and # of tissue cores): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specimen to be sent for Emory processing (but only research, no accessioning or diagnostic review). Specimen to be picked up by research coordinator to be delivered to fifth floor Winship Cancer and Tissue Pathology (Dianne Alexis 404-778-5108). PPMS order will need to have already been placed.

\*\*\*\*Amount of tissue required: (gauge and # of tissue cores): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Research tissue but also need for accessioning and pathological interpretation.

Please provide routine order for standard-of-care biopsy in addition to this form. An official “EML Surgical Pathology Test Request” form, this form, and the biopsy specimen split into two (2) separate containers to be delivered to surgical pathology. Research portions of the specimen to be picked up by research study coordinator and handled per specified research protocol (send-out vs Emory PPMS order).

\*\*\*\*Amount of tissue required: (gauge and # of tissue cores): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT: Name of ordering physician

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ordering physician signature Date signed (Required) Time signed (Required)