



*CellSearch™ Circulating Tumor Cell Test for Metastatic Breast Cancer  
Requisition*

**Patient Demographics**

Last Name	First Name	M.I.
Home Address		
City	State	Zip
Phone	Social Security Number	
Date of Birth	Gender	
Bill To: <input type="checkbox"/> Primary Insurance <input type="checkbox"/> Secondary Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Other		
Policy Holder is: <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian		
Primary Insurance Company		Insurance Company Phone #
Insurance Billing Address		
Policy Number/ID #		Group Number
Secondary Insurance Company		Insurance Company Phone #
Insurance Billing Address		
Policy Number/ID #		Group Number
Diagnosis (must be breast cancer to be covered by insurance or Medicare)		



**Carolina BioOncology Institute**  
CANCER THERAPY & RESEARCH CENTER

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**Ordering Physician**

Physician Name	Practice Name	
Address		
City	State	Zip
Business Phone	Fax	
National Provider Identification #		

\_\_\_\_\_  
Requesting Physician Signature

\_\_\_\_\_  
Date

I hereby authorize Carolina BioOncology Institute, PLLC, to release information acquired in the course of my treatment to insurance carriers, Medicare, attorneys, or agencies involved in the payment of my account as well as any physicians assisting in my care. I hereby assign payment directly to Carolina BioOncology Institute, PLLC, for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I understand that this consent will remain in effect as long as I or my dependent remains a patient or until revoked, in writing, by myself.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship (if other than patient)  
\_\_\_\_\_



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**Specimen Requirements and Handling:**

1.) Collect 10ml (minimum 7.5ml) of whole blood in the CellSave® Preservative Tube provided. Record date, time and initials below.

• **DO NOT** collect sample in EDTA, sodium heparin or ACD tubes. **Specimens will not be processed if they are not in the CellSave® Preservative Tube.**

2.) Tube should be gently inverted 8 times after draw and transported at room temperature.

3.) Specimens need to be processed within 72 hours of collection. Therefore, submit samples within 24 hours of blood draw to ensure timely delivery.

• Collect prior to new therapy and at follow-up visits (prior to administration of a new cycle of therapy) and allow at least 7 days after administration of doxorubicin.

4.) Complete the CBI Requisition form.

5.) Call **Carolina BioOncology Institute** at **704.947.6599** for ordering and shipping information or to schedule a pick up.

\_\_\_\_\_  
**Date blood collected**

\_\_\_\_\_  
**Phlebotomist initials**

\_\_\_\_\_  
**Time blood collected**

**Please check this box to request more tubes.**

**Number of tubes** \_\_\_\_\_