OFFICE

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Afirma Request Form

Form available online at www.aipathology.com, Test Directory, Request & Forms

Request Date: _____

Referring/Treating Physician: _____

Patient's Name and DOB: _____

AIP accession Number or Date of Service: _____

Specimen Source (Ex: A, B, or C): _____

Test Requested:

- ☐ Unified Afirma GSC (Afirma GSC, XA and GRID)
- ☐ Afirma TERT

Additional Comments:

_____

_____

_____

Referring/Treating Physician Signature: _____

Please fax completed Afirma request form to AIP clerical staff at (715) 203-1151.