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Afirma Request

Also 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:

- ☐ Afirma GCS (Category 3 or 4)
- ☐ Afirma XA (Category 5 or 6)

Additional Comments:

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Referring/Treating Physician Signature: ______________________________________

Please fax completed Afirma request form to AIP clerical staff at (715) 847-2133.