

REQUEST FOR PATHOLOGY CONSULTATION



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BILL TO
 ACCOUNT
 PATIENT
 OTHER

PATIENT NAME (LAST, FIRST, MIDDLE)			
PREVIOUS LAST NAME (IF CHANGED IN LAST 5 YEARS)			
MEDICAL RECORD NUMBER (IF APPLICABLE)		OFFICE/PATIENT ID NUMBER	
PATIENT SOCIAL SECURITY NO.		DATE OF BIRTH	AGE SEX
SEND COPY OF INSURANCE CARD BACK & FRONT OR COMPLETE BELOW INFORMATION IN FULL			
PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE), IF OTHER THAN PATIENT			
RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT			
STREET ADDRESS OF INSURED/RESPONSIBLE PARTY APT #			
CITY	STATE	ZIP	PHONE NO.
MEDICARE NUMBER		MEDICAID NUMBER (Attach copy of eligibility form)	
INSURANCE CO. NAME			
MEMBER / INSURED ID #		GROUP #	
INSURANCE ADDRESS			
CITY	STATE	ZIP	
EMPLOYER NAME/EMPLOYER #		INSURED SOCIAL SECURITY # (if not patient)	
ICD10 DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)			

DATE COLLECTED	TIME	AM PM
TIME IN FORMALIN (FOR BREAST BIOPSY SPECIMENS)		
REFERRING PHYSICIAN AND NPI (MUST INCLUDE)		
		NPI _____
<input type="checkbox"/> Call Results to: () <input type="checkbox"/> Fax		
Send Duplicate Report to:		
CLIENT # OR NAME: _____		
ADDRESS: _____		
CITY: _____ STATE _____ ZIP _____		

INFORMATION BELOW IS IMPORTANT FOR PROPER INTERPRETATION

CLINICAL DIAGNOSIS: _____

PERTINENT CLINICAL HISTORY / OPERATIVE FINDINGS: _____

PREVIOUS SURGERY (IF EXAMINED AT THIS LAB INCLUDE PATHOLOGY NO.): _____

IF SKIN BIOPSY, TYPE OF BIOPSY:
 Punch Shave Incisional Excisional Excisional with margin examination

SITE(S) OF BIOPSY (USE ONE REQUISITION PER PATIENT)

IF GYN SPECIMEN: LMP _____ PREVIOUS PAP DATE: _____

PREVIOUS BIOPSY OR PAP #: _____

Check if Pap was submitted simultaneously with biopsy
 Oral contraceptives Pregnant Post Menopausal
 Post Partum Post Abortion Abnormal Bleeding
 DES Exposure IUD Hormonal Therapy (Specify below)

ADDITIONAL INFORMATION: _____

HPV Reflex for ASCUS LGSIL HGSIL
 HPV only-No Pap HPV High Risk
 HPV 16/18 Reflex only Chlamydia/GC
 HSV 1 & 2 Trichomonas BD Affirm Panel

DID YOU REMEMBER...
 TO INCLUDE DIAGNOSIS CODE(S)?
 TO REQUEST OR MARK TEST(S)?

ONE OF THE FOLLOWING MUST BE CHECKED (REQUIRED)

NON-Medicare Patient
 Medicare Patient - Screening Pap; routine (reimbursable once every 2 years).
 Medicare Patient - Screening Pap; high risk of cervical cancer and physician recommends screening more often than every two years based on medical history (reimbursable once every year)
 Medicare Patient - Pap Smear, HPV, VD tests; history of abnormality or signs or symptoms of medical necessity, (appropriate ICD-9 codes must be listed in box above.)

MUST ATTACH ADVANCE BENEFICIARY NOTICE

F# _____	FOR OFFICE USE	DATE RECEIVED:
S# _____		UT PATHOLOGY CASE #:
M# _____	SEND TOP 3 COPIES WITH SPECIMEN	

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