REQUEST FOR PATHOLOGY CONSULTATION

THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER AT HOUSTON

DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE
6431 Fannin, MSB 2.008, Houston, Texas 77030
Outreach Lab: 713-500-5258 Fax: 713-500-0783
http://pathology.uth.tmc.edu/utlab/

BILL TO
☐ ACCOUNT
☐ PATIENT
☐ OTHER

REFERRED BY

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

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: ☐ SELF ☐ SPOUSE ☐ 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)		

ICD9 DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

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 for woman >30	
☐ No HPV wanted	☐ Chlamydia	☐ GC

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**

F ☐ **Medicare Patient -** Screening Pap; routine (reimbursable once every 2 years).

F ☐ **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# _____
S# _____
M# _____

FOR OFFICE USE

DATE RECEIVED:

UT PATHOLOGY CASE #:

SEND TOP 3 COPIES WITH SPECIMEN