Cytology / Anatomic / GI Pathology Requisition

BIOLAB
BIOLOGICAL LABORATORY, INC.
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☐ Fax Results

Enter information to send results

BILLING TO and PATIENT INFORMATION

LAST NAME	FIRST	M.I.	COLLECTION DATE / /	SEX ☐M ☐F	
ADDRESS			CITY	STATE	ZIP CODE
PATIENT ID #	D.O.B. / /		CHART #		PATIENT'S PHONE No.

☐ DOCTOR ☐ PATIENT ☐ MEDI-CAL ☐ MEDICARE ☐ MEDI-MEDI

☐ INSURANCE RELATIONSHIP TO RESPONSIBLE PARTY ☐ SELF ☐ CHILD ☐ GUARDIAN ☐ SPOUSE ☐ OTHER

● WITHOUT PROPER AND COMPLETE BILLING INFORMATION CLIENT/DOCTOR WILL BE BILLED. FOR INSURANCE BILLING, A LEGIBLE COPY OF INDIVIDUAL INSURANCE MEMBERSHIP CARD IS REQUIRED.

INSURANCE INFO:
MEDICARE, MEDI-CAL #

ADVANCE BENEFICIARY NOTICE

NOTE: If Medicare doesn't pay for __________ (test ordered) you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare/Medical & Private Insurance may not pay for the _______________ (test ordered).

✗ ______________________ ______________________ ______________________
INSURED/PATIENT SIGNATURE PATIENT PRINTED NAME DATE

ICD-10 CODES

CLINICAL DATA - Symptoms, Signs, and History

CYTOLOGY

☐ 801 PAP SMEAR
☐ 4522 HPV
☐ 8011 PAP W/ HPV if Ascus
☐ 5061 URINE CYTOLOGY
☐ 3994 ANAL PAP
☐ 3995 FNA (specify)
☐ OTHER:

SOURCE: C | V | E LMP
CLINICAL HISTORY:

☐ PREGNANT ☐ POSTMENOPAUSAL ☐ IUD
☐ POST PARTUM ☐ LIQUID BASE PAP ☐ BCP
☐ HYSTERECTOMY ☐ HORMONAL ☐ OTHER

COLLECTION

Date ____________

Time ____________ AM / PM

# of Containers ____________

HISTOLOGY

GENERAL

Specimen #	Type/Site

☐ 805 **BIOPSY**

Source Site(s):
1)
2)
CLINICAL HISTORY:
DIAGNOSIS:

UPPER GI SPECIMEN

Specimen #	From	Esophagus	EG Junction	Fundus	Body	Antrum	Duodedum (Bulb)	Duodedum (Small Bowel)	Liver	Proximal	Distal	Other (Specify)	Endoscopic Findings
	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

LOWER GI SPECIMEN

Specimen #	From	Ileum	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Rectum	Proximal	Mid	Distal	Other (Specify)	Endoscopic Findings
	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ ____	
	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ ____	
	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ ____	
	____ cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ ____	

BIOPSY DATA

☐ Histology
☐ Consultation: On referred slides*
☐ Consultation: Referred material requiring slide prep*
☐ Cytology (Brushings)

**Please send pathology reports with all consultations*

CYTOLOGY

☐ FNA Location ____________

Size ________ cm — *Circle:* Solid / Cystic

Duration ____________ Solitary / Multiple

Consistency ____________ Circumscribed / Diffuse

☐ Brushing ____________
☐ Washing ____________
☐ Fluids ____________

■ 506 URINE CITOLOGY

SPECIAL INDICATIONS

ENDOSCOPIC CODES

1. Barrett's Mucosa	3. Erythema	5. Hiatal Hernia	7. Nodularity	9. Polyp	11. Pseudomembrane	13. Ulcer	15. Random bx
2. Erosion	4. Granularity	6. Mass	8. Normal	10. Polyposis	12. Stricture	14. H. Pylori	16. Other ________