LAB COPY

ODL
OncoDiagnostic Laboratory, Inc.
"A Partnership in Excellence"

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GENERAL SURGICAL PATHOLOGY/CYTOLOGY TEST REQUISITION

ACCOUNT INFORMATION

ACCOUNT NO. TELEPHONE NO.

ACCOUNT NAME AND ADDRESS

REQUESTING PHYSICIAN

PATIENT INFORMATION

PATIENT SOC. SEC. NO. M. F. SEX DATE OF BIRTH

PATIENT LAST NAME FIRST NAME M.I.

STREET ADDRESS

CITY STATE ZIP CODE

PATIENT CHART NO. (OPTIONAL) PATIENT TELEPHONE NO. ( )

BILLING INFORMATION (Must Be Completed)

- ☐ BILL TO MEDICARE NO.:
- ☐ BILL TO ACCOUNT
- ☐ BILL TO PATIENT (Address Given)
- ☐ BILL TO MANAGED CARE PLAN
- ☐ BILL PATIENT INSURANCE

MEDICARE NO.

INSURANCE/MANAGED CARE NAME

STREET ADDRESS

CITY STATE ZIP CODE

POLICY NO GROUP NO.

IF GROUP, NAME OF EMPLOYER

INSURED OR RESPONSIBLE PARTY, IF OTHER THAN PATIENT
LAST NAME FIRST NAME

PATIENT RELATIONSHIP TO INSURED
INSURED SOC. SEC. NO. ☐ SPOUSE ☐ CHILD ☐ OTHER

☐ BILL TO MEDICAID: MEDICAID NUMBER EFFECTIVE DATE STATE

PLEASE ATTACH ADDITIONAL SECONDARY INSURANCE INFORMATION

PATIENT AUTHORIZATION

PATIENT AUTHORIZATION:
I authorize any holder of medical or other information about me to release to the Social Security administration, its intermediates, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits.

PATIENT SIGNATURE DATE

DIAGNOSIS ICD-9 CODE:

CLINICAL INFORMATION

PREVIOUS MEDICAL HISTORY:

PRESENT SIGNS AND SYMPTOMS

PRESENT AND PAST MEDICATION(S)

PREVIOUS TREATMENT(S)

☐ SURGERY ☐ RADIATION THERAPY ☐ CHEMOTHERAPY

☐ OTHER

BIOPSY INFORMATION

SPECIMEN TYPE: ☐ TISSUE BIOPSY ☐ FNA

☐ OTHER

DATE OF BIOPSY: ___/___/___ DATE BIOPSY RECEIVED: ___/___/___

PRE-OP DX:

POST-OP DX:

ANATOMIC SITE(S) OF BIOPSY:

1.
2.
3.
4.
5.

PROGNOSTIC MARKERS

☐ DNA ☐ P53 ☐ ER ☐ PR ☐ EGFR ☐ HER2 ☐ CerB2

☐ CATHEPSIN D ☐ Ki-67

☐ OTHER

DO YOU NEED BIOPSY KITS? ☐ YES HOW MANY