LAB COPY

PLASTIC SURGERY PATHOLOGY/CYTOLOGY TEST REQUISITION

812 HURON ROAD, SUITE 520, CLEVELAND, OHIO 44115 • PHONE: (800) 527-6446 • FAX (216) 861-1720

Account Information

ACCOUNT NO. TELEPHONE NO.

ACCOUNT NAME AND ADDRESS

REQUESTING PHYSICIAN

Patient Information

Last Name: ______ First Name: ______ M.I: ______

Street Address: ______ Apt#: ______

City: ______ State: ______ Zip Code: ______

Phone: ______ Sex: ______ Date of Birth: ____/____/____

Social Security#: ______ Chart#: ______

Clinical Information Please provide relevant data to specimen Interpretation

______

______

______

______

______

Billing Information ☐ Front and back copy of insurance card attached

Name of Insured: ______ Relationship To Insured: ☐Self ☐Spouse ☐Dependent

Insurance Company Name: ______

Street Address: ______

City: ______ State: ______ Zip Code: ______

Member ID #: ______ Grp. #: ______

Medicare / Medicaid#: ______ Referral #: ______

TEST REQUESTED

BREAST Bx Date: ______

☐**Histology** ☐**Cytology** **ICD-9:** ______

Prognostic Test For Cancer

☐ ER, PR & HER-2/Neu ☐ ER & PR

☐ HER-2/Neu ☐ Reflex to HER-2/Neu if IHC equal +2

☐ DNA by image anaylsis ☐ Ki67 ☐ P53

Jar #	Specimen Location: Lt Breast	Rt Breast	Nipple	Subareolar	Axilla	Clock Position	Collection Method: Mammotone	Stereotactic	Surg./ Excis.	Ultrasound Guided
1	☐	☐	☐	☐	☐	______	☐	☐	☐	☐
2	☐	☐	☐	☐	☐	______	☐	☐	☐	☐
3	☐	☐	☐	☐	☐	______	☐	☐	☐	☐

SKIN (Dermatopathology) Bx Date: ______ **ICD-9:** ______ ☐ Histology ☐ Alopecia ☐ Direct Immuno ☐ Consult

Jar #	Specimen Location	Clinic Dx. / Rule Out	Read Margins
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			