

LIVER PATHOLOGY CONSULTATION REQUISITION

<<FORM_ID>>

<p>PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)</p> <hr/> <p>Last Name _____ First _____ MI _____</p> <hr/> <p>Address _____ Birth Date _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <hr/> <p>City _____ SS # _____</p> <hr/> <p>State _____ Zip _____ Home Phone _____</p> <hr/> <p>Hospital/Physician Office Patient ID # _____ Accession # _____</p> <hr/> <p>MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.</p> <p>INSURANCE BILLING INFORMATION (PLEASE PRINT IN BLACK INK)</p> <p>BILL TO: <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p>PATIENT STATUS: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p>WORKERS COMP: <input type="checkbox"/> Yes <input type="checkbox"/> No DOI: _____</p> <p>PRIMARY: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Ins. _____ <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child</p> <hr/> <p>Subscriber Last Name _____ First _____ MI _____</p> <hr/> <p>Beneficiary / Member # _____ Group # _____</p> <hr/> <p>Claims Address _____ City _____ State _____ Zip _____</p> <p>SECONDARY: <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach) ABN: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____</p> <p><input type="checkbox"/> MEDICAL LIVER BIOPSY <input type="checkbox"/> LIVER TRANSPLANT BIOPSY (date of transplant: ____/____/____) Diagnosis on explanted liver _____</p> <p>Current clinical presentation (below or attach). Risk factors for fatty liver disease (Diabetes Mellitus (type 1 or 2), obesity, TPN, alcohol use, etc.), cardiovascular disease, portal hypertension, chronic hepatitis, known/suspected autoimmune hepatitis, cholestatic liver disease). _____ _____</p> <p>Medications/toxins (list any): _____</p> <hr/> <p>Liver function tests: <input type="checkbox"/> AST _____ <input type="checkbox"/> ALT _____ <input type="checkbox"/> Alkaline phosphatase _____ <input type="checkbox"/> Bilirubin _____</p> <p>Most recent to the liver biopsy with corresponding date, prior value if available): ____/____/____</p> <p>Positive autoantibodies (titers if available): <input type="checkbox"/> ANA <input type="checkbox"/> AMA <input type="checkbox"/> SMA <input type="checkbox"/> Others: _____</p> <p><input type="checkbox"/> Not performed</p> <p><input type="checkbox"/> Alpha-1 antitrypsin phenotype _____ <input type="checkbox"/> Ceruloplamin _____ <input type="checkbox"/> 24h copper _____</p> <p><input type="checkbox"/> IgG <input type="checkbox"/> IgM</p> <p>Viral Serologies: <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Hepatitis D <input type="checkbox"/> Hepatitis E <input type="checkbox"/> CMV <input type="checkbox"/> EVB <input type="checkbox"/> HSV <input type="checkbox"/> Not available/not performed</p> <p>*If treated Hepatitis C, please provide HCV viral RNA: _____</p> <p>Imaging studies: <input type="checkbox"/> MRCP <input type="checkbox"/> ERCP <input type="checkbox"/> US (if available) _____</p> <hr/> <p><input type="checkbox"/> LIVER LESION</p> <p>History of chronic liver disease: please specify (hepatitis B, hepatitis C, autoimmune hepatitis, congestive hepatopathy, fatty liver disease, etc.): _____ _____</p> <p>Lesions in other sites (pancreas, lung, etc.): _____</p> <hr/> <p>Serum markers (please check if elevated): <input type="checkbox"/> AFP <input type="checkbox"/> CEA <input type="checkbox"/> CA 19-9</p> <p>Medications/toxins (oral contraceptives, anabolic steroids, etc.): _____</p> <hr/> <p>Imaging studies (description of lesion/s): _____ _____</p>	<p style="text-align: center;">CLIENT INFORMATION</p> <hr/> <p>REFERRING PHYSICIAN CONTACT</p> <p>Physician Name _____</p> <hr/> <p>Physician NPI# _____</p> <hr/> <p>Physician Phone _____</p> <hr/> <p>Physician Email _____</p> <hr/> <p><input type="checkbox"/> Call Results to phone number: (_____) _____</p> <hr/> <p><input type="checkbox"/> Fax report to: (_____) _____</p> <hr/> <p>SPECIMEN INFORMATION</p> <p>Collection Date: ____/____/____ Time: _____</p> <hr/> <p style="background-color: #ffffcc; padding: 5px;">Please provide paraffin block or 10 unstained slides with case. Send specimen to 2119 E. 93rd St./L15, Cleveland, OH 44106</p>
---	---