Cleveland Clinic Laboratories
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

SURGICAL PATHOLOGY REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date | Sex ☐ M ☐ F

City | SS #

State | Zip | Home Phone

Hospital/Physician Office Patient ID # | Accession #

CLIENT INFORMATION

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.

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

BILL TO: ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: ____/____/____

PRIMARY: ☐ Medicare ☐ Medicaid (Ohio only) ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

SECONDARY: ☐ No ☐ Yes (if yes, please attach) **ABN:** ☐ Yes ☐ No

ORDERING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____

DIAGNOSIS _____

CLINICAL HISTORY _____

SPECIMEN INFORMATION

Collection Date: ____/____/____ Time: _____

Body Site: _____ Client Case #: _____

Specimen ID# _____

☐ Blocks: Unstained_____ Stained_____

☐ Slides: Unstained_____ Stained_____

☐ Other: _____

CONSULTATION ON PREPARED SLIDES/BLOCKS

Biopsy: Specimen Types(s)/Sources(s):

A) _____

B) _____

C) _____

REQUIRED GYN SPECIMEN INFORMATION

LMP

PAP

DRUGS/CHEMO Rx

OP

RAD Rx

Chromosome Analysis

_____ Cytogenetics / Chromosome Study, Products of Conception

_____ Cytogenetics / Chromosome Study, Tissue Other: _____

Note: Transport in Saline, Formalin is unacceptable; Stability: 48 Hours Refrigerated

Time of formalin fixation required: (Check one)

☐ Less than 6 hours
☐ 6-48 hours: Specify _____
☐ Greater than 48 hours
☐ Cold Ischemia Time (breast markers)

Fixation type for this Specimen: _____

☐ Electron Microscopy (must be in Glutaraldehyde)
☐ Direct Immunoflourescence (DIF)
☐ Cell Pellet: EGFR Mutational Analysis (ASPCR)
☐ Paraffin Block: *ALK* (FISH)
☐ Paraffin block: Immunohistochemistry (Indicate Stain)
☐ Paraffin Block: EGFR Mutational Analysis (ASPCR)
☐ Paraffin block: ER/PR (IHC)
☐ Paraffin block: HER2 (FISH)
☐ Paraffin block: *KRAS* Mutational Analysis (ASPCR)
☐ Paraffin block: *BRAF* Mutational Analysis (ASPCR)
☐ Paraffin block: HER2 (Erb-b2) HER2 (IHC)
☐ ThinPrep Cytology Slide: *ALK* (FISH)

SPECIAL REQUEST: _____

*CPT codes available online at clevelandcliniclabs.com 8/2023

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