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

LIVER PATHOLOGY CONSULTATION 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

REFERRING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

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 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: _____/_____/_____

ABN: ☐ Yes ☐ No **WORKERS COMP:** ☐ Yes ☐ No DOI: _____

PRIMARY: ☐ Medicare ☐ Medicaid ☐ 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)

SPECIMEN INFORMATION

Collection Date: _____/_____/_____ Time: _____

Please provide paraffin block or 10 unstained slides with case.
Send specimen to 2119 E. 93rd St./L15, Cleveland, OH 44106

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

☐ MEDICAL LIVER BIOPSY ☐ LIVER TRANSPLANT BIOPSY (date of transplant: _____/_____/_____)

Diagnosis on explanted liver

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).

Medications/toxins (list any): _____

Liver function tests: ☐ AST_____ ☐ ALT_____ ☐ Alkaline phosphatase_____ ☐ Bilirubin_____

Most recent to the liver biopsy with corresponding date, prior value if available): _____/_____/_____

Positive autoantibodies (titers if available): ☐ ANA ☐ AMA ☐ SMA ☐ Others: _____

☐ Not performed

☐ Alpha-1 antitrypsin phenotype _____ ☐ Ceruloplamin _____ ☐ 24h copper _____

☐ IgG ☐ IgM

Viral Serologies: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Hepatitis D ☐ Hepatitis E ☐ CMV ☐ EVB ☐ HSV ☐ Not available/not performed

*If treated Hepatitis C, please provide HCV viral RNA: _____

Imaging studies: ☐ MRCP ☐ ERCP ☐ US (if available) _____

☐ LIVER LESION

History of chronic liver disease: please specify (hepatitis B, hepatitis C, autoimmune hepatitis, congestive hepatopathy, fatty liver disease, etc.):

Lesions in other sites (pancreas, lung, etc.): _____

Serum markers (please check if elevated): ☐ AFP ☐ CEA ☐ CA 19-9

Medications/toxins (oral contraceptives, anabolic steroids, etc.):

Imaging studies (description of lesion/s):

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