Cleveland Clinic Laboratories

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

PATHOLOGY CONSULT 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

ORDERING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

☐ Additional 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 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 ☐ 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:** ☐ No ☐ Yes

SPECIMEN INFORMATION

Collection Date: _____/_____/_____ Time: _____

Body Site: _____ Client Case #: _____

Specimen ID# _____

☐ Blocks _____ ☐ Stained slides: number _____

☐ Unstained/Unbaked Slides: number _____
(to preserve the ability to perform molecular testing, if indicated)

☐ Other: _____

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

CLINICAL INFORMATION

☐ **See Attached Letter** ☐ **Copy of Pathology Report: (REQUIRED)**

Brief Clinical History: _____

PATHOLOGY CONSULTATION REQUEST

☐ **Pathology Consultation** **Please check below for a Preferred Subspecialty Group**

In addition to what has been ordered, the Cleveland Clinic Pathologist is authorized to add other testing as needed to assist in evaluation.

☐ Breast
☐ Cardio
☐ Cyto
☐ Derm
☐ GI
☐ GU
☐ GYN
☐ Head/Neck
☐ Heme
☐ Kidney
☐ Neuro
☐ Ocular
☐ Ortho/Bone (imaging reports/ images strongly recommended)
☐ Pulmonary
☐ Soft Tissue

Liver (*provide required information)
☐ Random/Medical Liver Biopsy
*Clinical Notes and Laboratory Test Results
☐ Liver Lesion
*Imaging Studies
☐ Transplant Liver Biopsy: date of transplant _____/_____/_____
*Clinical Notes and Laboratory Test Results

For Molecular Pathology and Immunohistochemistry Requisitions, see clevelandcliniclabs.com/laboratory-resources/requisitions-forms/

*CPT codes available online at clevelandcliniclabs.com 7/2024

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