

<p><b>PATIENT INFORMATION</b> (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><b>INSURANCE BILLING INFORMATION</b> (PLEASE ATTACH CARD OR PRINT IN BLACK INK)</p> <p><b>BILL TO:</b> <input type="checkbox"/> Client/Institution <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance (Complete insurance information below) <input type="checkbox"/> Patient</p> <p><b>PATIENT STATUS:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Non-Hospital Patient Hospital discharge date: ____/____/____</p> <p><b>PRIMARY:</b> <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><b>SECONDARY:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (if Yes, please attach) <b>ABN:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <hr/> <p><b>DIAGNOSIS CODE (REQUIRED)</b> ICD-10 Codes 1. _____ 2. _____ 3. _____</p> <p><b>CLINICAL INFORMATION</b> <input type="checkbox"/> See Attached Letter <input type="checkbox"/> Copy of Pathology Report: (REQUIRED)</p> <p>Brief Clinical History: _____</p> <hr/> <p>_____</p> <hr/> <p>_____</p> <hr/> <p>_____</p> <hr/> <p>_____</p>	<p><b>CLIENT INFORMATION</b></p> <hr/> <p><b>ORDERING PHYSICIAN CONTACT</b></p> <p>Physician Name _____</p> <hr/> <p>Physician NPI# _____</p> <hr/> <p>Physician Phone _____</p> <hr/> <p>Physician Email _____</p> <p><input type="checkbox"/> Call Results to phone number: ( _____ ) _____</p> <p><input type="checkbox"/> Fax report to: ( _____ ) _____</p> <p><input type="checkbox"/> Additional fax report to: ( _____ ) _____</p> <hr/> <p><b>SPECIMEN INFORMATION</b></p> <p>Collection Date: ____/____/____ Time: _____</p> <hr/> <p>Body Site: _____ Client Case #: _____</p> <hr/> <p>Specimen ID# _____</p> <p><input type="checkbox"/> Blocks _____ <input type="checkbox"/> Stained slides: number _____</p> <p><input type="checkbox"/> Unstained/Unbaked Slides: number _____ (to preserve the ability to perform molecular testing, if indicated)</p> <p><input type="checkbox"/> Other: _____</p>																
<p><b>PATHOLOGY CONSULTATION REQUEST</b></p> <p><input type="checkbox"/> Pathology Consultation <b>Please check below for a Preferred Subspecialty Group</b></p> <p>In addition to what has been ordered, the Cleveland Clinic Pathologist is authorized to add other testing as needed to assist in evaluation.</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Breast</td> <td><input type="checkbox"/> GI</td> <td><input type="checkbox"/> Heme</td> <td><input type="checkbox"/> Ortho/Bone (imaging reports and images [CD] strongly recommended)</td> </tr> <tr> <td><input type="checkbox"/> Cardio</td> <td><input type="checkbox"/> GU</td> <td><input type="checkbox"/> Kidney</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Cyto</td> <td><input type="checkbox"/> GYN</td> <td><input type="checkbox"/> Neuro</td> <td><input type="checkbox"/> Pulmonary</td> </tr> <tr> <td><input type="checkbox"/> Derm</td> <td><input type="checkbox"/> Head/Neck</td> <td><input type="checkbox"/> Ocular</td> <td><input type="checkbox"/> Soft Tissue</td> </tr> </table> <p>Liver (*provide required information)</p> <p><input type="checkbox"/> Random/Medical Liver Biopsy *Clinical Notes and Laboratory Test Results</p> <p><input type="checkbox"/> Liver Lesion *Imaging Report(s)</p> <p><input type="checkbox"/> Transplant Liver Biopsy: date of transplant ____/____/____ *Clinical Notes and Laboratory Test Results</p> <p>For Molecular Pathology and Immunohistochemistry Requisitions, see <a href="http://clevelandcliniclabs.com/laboratory-resources/requisitions-forms/">clevelandcliniclabs.com/laboratory-resources/requisitions-forms/</a></p>		<input type="checkbox"/> Breast	<input type="checkbox"/> GI	<input type="checkbox"/> Heme	<input type="checkbox"/> Ortho/Bone (imaging reports and images [CD] strongly recommended)	<input type="checkbox"/> Cardio	<input type="checkbox"/> GU	<input type="checkbox"/> Kidney		<input type="checkbox"/> Cyto	<input type="checkbox"/> GYN	<input type="checkbox"/> Neuro	<input type="checkbox"/> Pulmonary	<input type="checkbox"/> Derm	<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Ocular	<input type="checkbox"/> Soft Tissue
<input type="checkbox"/> Breast	<input type="checkbox"/> GI	<input type="checkbox"/> Heme	<input type="checkbox"/> Ortho/Bone (imaging reports and images [CD] strongly recommended)														
<input type="checkbox"/> Cardio	<input type="checkbox"/> GU	<input type="checkbox"/> Kidney															
<input type="checkbox"/> Cyto	<input type="checkbox"/> GYN	<input type="checkbox"/> Neuro	<input type="checkbox"/> Pulmonary														
<input type="checkbox"/> Derm	<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Ocular	<input type="checkbox"/> Soft Tissue														