

<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 ATTACH CARD OR PRINT IN BLACK INK)</p> <p>BILL TO: <input type="checkbox"/> Client/Institution (Send invoice to: Name _____ Fax/Email _____) <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>PRIMARY: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid (OH only) <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"/> No <input type="checkbox"/> Yes</p> <hr/> <p>DIAGNOSIS CODE (REQUIRED) ICD-10 Codes 1. _____ 2. _____ 3. _____</p> <p>CLINICAL INFORMATION <input type="checkbox"/> Copy of Pathology Report: (REQUIRED) <input type="checkbox"/> See Attached Letter</p> <p>Brief Clinical History: _____</p> <hr/> <p>PATHOLOGY CONSULTATION REQUEST</p> <p>*Representative block(s) and/or 10 unstained slides are required for this specialty. For all others, strongly recommended.</p> <p><input type="checkbox"/> Pathology Consultation</p> <p><input type="checkbox"/> Breast</p> <p><input type="checkbox"/> Cardio</p> <p><input type="checkbox"/> Derm</p> <p><input type="checkbox"/> GI</p> <p><input type="checkbox"/> GU/Adrenal</p> <p><input type="checkbox"/> GYN</p> <p><input type="checkbox"/> Head/Neck/Oral/Thyroid (No thyroidectomies greater than 20 H&E slides)</p> <p><input type="checkbox"/> Bone Marrow/Heme*</p> <p><input type="checkbox"/> Lymphoma*</p> <p><input type="checkbox"/> Neuro*</p> <p><input type="checkbox"/> Ocular</p> <p><input type="checkbox"/> Ortho/Bone (imaging reports and images [CD] strongly recommended)</p> <p><input type="checkbox"/> Pediatric/Perinatal</p> <p><input type="checkbox"/> Soft Tissue</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Please check below for a Preferred Subspecialty Group</p> <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>Medical Kidney (provide required information)</p> <p><input type="checkbox"/> Random Native Medical Kidney Biopsy – Clinical Notes and Laboratory Test Results</p> <p><input type="checkbox"/> Kidney Transplant Biopsy: date of transplant ____/____/____ – Clinical Notes and Laboratory Test Results</p> <p>Pulmonary (provide required information)</p> <p><input type="checkbox"/> Neoplastic Pathology – Clinical notes from oncologist or pulmonologist – Report of CT imaging studies prior to biopsy</p> <p><input type="checkbox"/> Non-neoplastic Lung Disease – Clinical notes from pulmonologist – Report of chest CT imaging studies prior to the biopsy</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Cytology</p> <p>Reason for Consultation: _____</p> <p><input type="checkbox"/> Submit block or 10 unstained slides: _____ block _____ slides – Clinical history, pathology report, imaging reports – Surgical pathology report</p> <p>Are surgical specimens being sent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has case been screened by cytologist/pathologist? <input type="checkbox"/> Yes <input type="checkbox"/> No NOTE: Unscreened cases will not be accepted</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> </div>	<p>CLIENT INFORMATION</p> <hr/> <p>ORDERING PHYSICIAN CONTACT</p> <p>Physician Name _____</p> <p>Physician NPI# _____</p> <p>Physician Phone _____</p> <p>Physician Email _____</p> <p><input type="checkbox"/> Call critical results to: (_____) _____</p> <p><input type="checkbox"/> Fax report to: (_____) _____</p> <p><input type="checkbox"/> Additional fax report to: (_____) _____</p> <hr/> <p>SPECIMEN INFORMATION</p> <p>Please send appropriate block(s) or unstained slides (unbaked and charged)</p> <p>Collection Date: ____/____/____ Time: _____</p> <p>Body Site: _____ Client Case #: _____</p> <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> <hr/> <p>FREQUENTLY REQUESTED TESTS</p> <p><input type="checkbox"/> Amyloid Typing by Mass Spectrometry <i>ATMS R</i></p> <p><input type="checkbox"/> Direct Immunofluorescence</p> <p><input type="checkbox"/> Head and Neck Next Generation Sequencing <i>HDNK</i></p> <p><input type="checkbox"/> NTRK by NGS <i>NTRK</i></p> <p><input type="checkbox"/> POLE Pyrosequencing <i>POLE</i></p> <p><input type="checkbox"/> Solid Tumor Fusion Next Generation Sequencing Panel <i>SRCNGS</i></p> <p><input type="checkbox"/> Targeted Oncology Panel Next Generation Sequencing Bone Marrow <i>TOPBM</i></p> <p><input type="checkbox"/> Targeted Oncology Panel Next Generation Sequencing Cytology <i>TOPCY</i></p> <p><input type="checkbox"/> Targeted Oncology Panel Next Generation Sequencing Other <i>TOPTO</i></p>
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For Molecular Pathology and Immunohistochemistry Requisitions, see clevelandcliniclabs.com/laboratory-resources/requisitions-forms/