ACUPATH LABORATORIES, INC.
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# SURGICAL PATHOLOGY TEST REQUEST FORM

SP001L

**ANY OMISSION MAY RESULT IN DELAY OF REPORT**

**PHYSICIAN SIGNATURE:**_____

DUPLICATE REPORT TO:_____

COMMENTS TO PRINT OUT ON REPORT:_____

**STAT** ☐ **DATE OBTAINED:**__/__/__ **TIME OBTAINED:**__:__ AM PM

CHECK MARGINS ☐ CONSULTATION ☐

CALL MD W/ RESULTS ☐ OTHER:_____

# OF BOTTLES:_____ PREVIOUS BX:_____

# OF SLIDES:_____ **ICD-9:**_____

**TEST REQUEST: HISTOPATHOLOGY**

☐ INCLUDES SPECIAL (BILLABLE) STAINS DETERMINED BY PATHOLOGIST
☐ PHYSICIAN MUST BE CONTACTED PRIOR TO PERFORMANCE OF SPECIAL (BILLABLE) STAINS

**BIOPSY METHOD:** ☐ PUNCH ☐ EXCISION ☐ INCISIONAL ☐ CORE
☐ CYST ASPIRATION ☐ VACUUM ASSISTED CORE ☐ STEREOTACTIC BIOPSY
☐ MRI GUIDED BIOPSY ☐ OTHER_____

☐ **CYTOLOGY**

☐ **HPV TISSUE (ISH)** If Screen +, do Subtype (6/11, 16/18, 31/33)

| BIOPSY SITE | SIZE | FNA | DURATION / HISTORY / CLINICAL DIAGNOSIS |
|---|---|---|---|
| ☐ *Perform Cytospin if necessary* | | | |
| A | | | |
| B | | | |
| C | | | |
| D | | | |

**CLINICAL DATA** ***(Required)***_____

**PATIENT INFORMATION** RACE (optional)

SS# _____ DATE OF BIRTH __/__/__ M ☐ F ☐

LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TEL. # _____ CHART # _____ PATH # _____

**PATIENT'S PRIMARY INSURANCE**

**BILL TO:** ☐ MEDICARE ☐ PATIENT ☐ OTHER ☐ NO FAULT ☐ WORKERS COMP

INSURED'S NAME_____ D.O.B.__/__/__

DATE OF ACCIDENT (IF NO FAULT/WORKERS COMP)__/__/__

PT RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

POLICY #_____ SS # _____

GROUP NAME/#_____ **REFERRAL #**_____

NAME OF INSURANCE CO._____

INSURANCE ADDRESS*_____

CITY_____ STATE_____ ZIP_____

***If previous biopsy on file with Acupath and same insurance, please check box ☐**

**SECONDARY INSURANCE**

INSURED'S NAME_____ D.O.B.__/__/__

PT RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

POLICY #_____ SS # _____

GROUP NAME/#_____ **REFERRAL #**_____

NAME OF INSURANCE CO._____

INSURANCE ADDRESS*_____

CITY_____ STATE_____ ZIP_____

***If previous biopsy on file with Acupath and same insurance, please check box ☐**

I authorize the release to my insurance carrier of any medical information necessary to process this claim, and I authorize payment of medical benefits directly to Acupath Laboratories, Inc. I understand that if I do not have insurance, I will be billed directly by Acupath Laboratories, Inc.

I also authorize release of my pathology results to my doctor utilizing all methods of transmission according to HIPAA regulations.

Patient Signature_____

**FOR LAB USE ONLY:**

SAMPLE

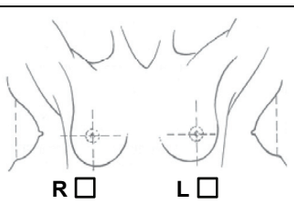
**BREAST TISSUE PATHOLOGY**

**DIAGNOSTIC, PROGNOSTIC AND THERAPEUTIC ANALYSIS**

☐ **ER/PR** ☐ **Her2/neu by (IHC)** ☐ **Ki67**

☐ **Her2/neu (IHC), Reflex to Her2/neu by FISH, PathVysion™ if** ☐ **1+** ☐ **2+** ☐ **3+**

☐ **OTHER:**_____



R ☐ L ☐

**NON-GYNECOLOGIC: CYTOLOGY TEST REQUEST**

***Breast Cytology*:**

☐ NIPPLE DISCHARGE FLUID __R __L

☐ HALO® BREAST PAP TEST (NAF) __R __L

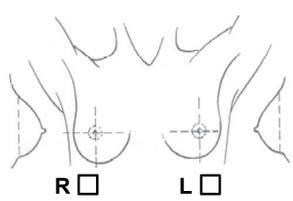
☐ FINE NEEDLE ASPIRATION (FNA) __R __L

***Urine Cytology*:**

☐ VOIDED URINE

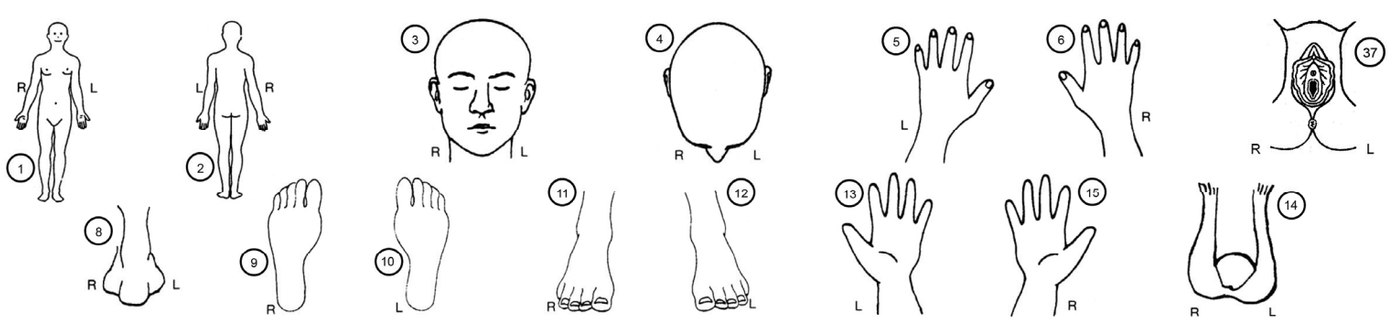
☐ POST CYSTOSCOPY

☐ OTHER:_____



R ☐ L ☐

**PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD OR FILL OUT INSURANCE SECTION**




Remove labels and affix to specimen bottles and bag.
(1 label per bottle, 1 label for bag)

**BAG**

A _____ C _____ OTHER _____

B _____ D _____ OTHER _____