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"FOR THE ABSOLUTE HIGHEST STANDARD IN GASTROINTESTINAL PATHOLOGY" © 2023

UPPER & LOWER GI PATHOLOGY TEST REQUEST FORM

GI2KBL

GI2KBL_69201

ANY OMISSION MAY RESULT IN DELAY OF REPORT

NOT FOR PATIENT USE

☐ TC ☐ GLOBAL

PHYSICIAN SIGNATURE _____

DUPLICATE REPORT TO _____

COMMENTS TO PRINT OUT ON REPORT: _____

STAT ☐ **DATE OBTAINED:** ___/___/___

CALL MD W/RESULTS ☐ CHECK MARGINS ☐

CALL MD IF CANCER ☐ CONSULTATION ☐

OTHER _____

ICD-10 CODES:

TEST REQUEST: HISTOPATHOLOGY

☐ NUMBER OF SPECIMEN BOTTLES* _____

*INCLUDES IHC AND SPECIAL (BILLABLE) STAINS DETERMINED BY PATHOLOGIST

☐ **GI Pathogen Panel**

☐ **BE FISH - PAN** ☐ **BE FISH - NODE**

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

CLINICAL INFORMATION / HISTORY

- ☐ ABDOMINAL PAIN
- ☐ ANEMIA
- ☐ BARRETT'S (HX)
- ☐ BLEEDING _____
- ☐ CANCER (PERSONAL HX) _____
- ☐ CANCER (FAMILY HISTORY) _____
- ☐ DYSPEPSIA
- ☐ DYSPHAGIA
- ☐ DIARRHEA
- ☐ HEME POSITIVE STOOL
- ☐ H. PYLORI (HX)
- ☐ IBD (PERSONAL HX)
- ☐ LYMPHOMA (HX)
- ☐ NAUSEA
- ☐ PAIN
- ☐ POLYPS (PERSONAL HX)
- ☐ RECTAL EXAM
- ☐ REFLUX BURN
- ☐ WEIGHT LOSS

INDICATIONS

- ☐ CANCER SURVEILLANCE
- ☐ COLITIS SURVEILLANCE
- ☐ R/O BARRETT'S
- ☐ R/O COLLAGENOUS AND LYMPHOCYTIC COLITIS
- ☐ R/O DYSPLASIA
- ☐ R/O EOSINOPHILIA
- ☐ R/O FUNGUS
- ☐ R/O GIARDIASIS
- ☐ R/O H. PYLORI
- ☐ R/O HEMORRHOIDS
- ☐ R/O IBD
- ☐ R/O MASS
- ☐ R/O PARASITES
- ☐ R/O SPRUE
- ☐ R/O POLYP
- ☐ R/O ULCERATIVE COLITIS
- ☐ R/O VIRAL INCLUSIONS
- ☐ R/O OTHER _____

OTHER HISTORY/INFORMATION

_____

ENDOSCOPIC FINDINGS

Please write the applicable number(s) for each corresponding bx specimen in the section on the right. Do not circle code #.

1. BARRETT MUCOSA
2. EROSION
3. ERYTHEMA
4. GRANULARITY
5. HIATAL HERNIA
6. ISCHEMIC BLEEDING
7. INFLAMMATION
8. MASS
9. NODULARITY
10. NORMAL
11. PARASITES
12. POLYP
13. POLYPOSIS
14. PSEUDOMEMBRANE
15. STRICTURE
16. ULCER
17. OTHER _____

UPPER GI TRACT

LOWER GI TRACT

PATIENT INFORMATION

RACE (optional)

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

LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TEL. # _____ CHART # _____ PATH # _____

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

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 _____

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 _____

UPPER GI BODY SPECIMEN — **ESOPHAGUS** — **STOMACH**

#	FROM		Upper	Lower	E.G Junct.	Cardia	Fundus, Body	Antral-Body	Antrum, Pylorus	Duodenum	Duodenum, Small Bowel	FINDINGS Use Codes	
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___

LOWER GI BODY SPECIMEN — **LOCATION**

#	FROM		Ileum	Ileo Cecal Valve	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Rectum	Other	PROXIMAL	MID	DISTAL	FINDINGS Use Codes	
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___
___	___	cm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	___	___

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

LABORATORY COPY