

Inform Diagnostics Breast Pathology Requisition



Shaded fields are required.

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CLIENT INFORMATION	
Referring Physician (Last, First)	
Phone	
Fax	

PATIENT INFORMATION							
Last Name	First Name	MI	Age	Sex	Date of Birth / /		
Street Address		Apt#	City			State	ZIP
Home Phone #	Cell Phone #	Medical Record #			Social Security #		

BILLING INFORMATION – PRIMARY INSURED				■ SECONDARY Please check box and attach copy of front and back of patient's card.			
We file all primary and secondary insurance plans if information is provided.							
Payer <input type="radio"/> Medicare <input type="radio"/> Insurance <input type="radio"/> Patient <input type="radio"/> Client <input type="radio"/> Other _____				Patient Status <input type="radio"/> Non-hosp <input type="radio"/> Hosp in-patient <input type="radio"/> Hosp out-patient			
Insurance Carrier			Policy Number/Insured ID Number		Group Number		
Claims Address			City		State	ZIP	
Claims Phone #			Policy Holder's Name				
Policy Holder's Relationship to Patient <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Dependent				Policy Holder's DOB / /		Policy Holder's Sex <input type="radio"/> M <input type="radio"/> F	



CLINICAL/FAMILY HISTORY (Please print)

ICD CODE(S)

SAMPLE INFORMATION
<input type="radio"/> Fixative: 10% neutral buffered formalin Date Specimen Collected: _____ Time Collected: _____ Time Placed in Fixative: _____ <input type="radio"/> Paraffin Block(s) Block # _____ <input type="radio"/> Unstained Slides Slide # _____

HISTOLOGY AND PROGNOSTIC WORK-UP
Reflex testing will be performed on all in situ & invasive carcinomas and will receive the standard prognostic biomarker testing. (ER/PR/Ki67/P53/HER2 IHC & HER2 CISH). <i>If different, please indicate the combination of individual markers preferred.</i>

PROGNOSTIC TISSUE TESTING
<input type="radio"/> ER <input type="radio"/> PR <input type="radio"/> Ki67 <input type="radio"/> P53 <input type="radio"/> HER2 by IHC <input type="radio"/> HER2 by CISH <input type="radio"/> Comprehensive Breast Cancer Panel (ER/PR/Ki67/P53/HER2 IHC & HER2 CISH)

SPECIMEN (Use second form if necessary)															
	Side	Clock Position	Site	Nature of Lesion	Biopsy Type	Testing Options	Lumpectomy								
A	<input type="radio"/> Left <input type="radio"/> Right		<input type="radio"/> Breast <input type="radio"/> Axilla <input type="radio"/> Chest Wall <input type="radio"/> Lymph node <input type="radio"/> Sentinel LN	<input type="radio"/> Nodule <input type="radio"/> Calcification <input type="radio"/> Cyst <input type="radio"/> Stellate Mass <input type="radio"/> Density <input type="radio"/> Other: _____ Distance from nipple: _____	<input type="radio"/> FNA <input type="radio"/> Core biopsy <input type="radio"/> Stereotactic <input type="radio"/> Wire-guided needle loc. <input type="radio"/> Other: _____	<input type="radio"/> Biopsy only <input type="radio"/> Flow & Biopsy <input type="radio"/> Flow only	<input type="radio"/> Double long _____ <input type="radio"/> Double short _____ <input type="radio"/> Single _____								
								B	<input type="radio"/> Left <input type="radio"/> Right		<input type="radio"/> Breast <input type="radio"/> Axilla <input type="radio"/> Chest Wall <input type="radio"/> Lymph node <input type="radio"/> Sentinel LN	<input type="radio"/> Nodule <input type="radio"/> Calcification <input type="radio"/> Cyst <input type="radio"/> Stellate Mass <input type="radio"/> Density <input type="radio"/> Other: _____ Distance from nipple: _____	<input type="radio"/> FNA <input type="radio"/> Core biopsy <input type="radio"/> Stereotactic <input type="radio"/> Wire-guided needle loc. <input type="radio"/> Other: _____	<input type="radio"/> Biopsy only <input type="radio"/> Flow & Biopsy <input type="radio"/> Flow only	<input type="radio"/> Double long _____ <input type="radio"/> Double short _____ <input type="radio"/> Single _____

In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics only to perform testing that is medically necessary for the diagnosis and treatment of patient.

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FOR LAB USE ONLY

Patient: _____	Patient: _____
Spec. A: _____	Spec. B: _____
DOB: _____ 00000000	DOB: _____ 00000000
Patient: _____	Patient: _____
Spec. C: _____	Spec. D: _____
DOB: _____ 00000000	DOB: _____ 00000000