

REQUEST FOR PATHOLOGY CONSULTATION



THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER AT HOUSTON

DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE

6431 Fannin, MSB 2.008, Houston, Texas 77030
Outreach Lab: 713-500-5258 Fax: 713-500-0783
<http://pathology.uth.tmc.edu/utlab/>

REFERRED BY

- BILL TO**
 ACCOUNT
 PATIENT
 OTHER

PATIENT NAME (LAST, FIRST, MIDDLE)			
PREVIOUS LAST NAME (IF CHANGED IN LAST 5 YEARS)			
MEDICAL RECORD NUMBER (IF APPLICABLE)		OFFICE/PATIENT ID NUMBER	
PATIENT SOCIAL SECURITY NO.		DATE OF BIRTH	AGE SEX
SEND COPY OF INSURANCE CARD BACK & FRONT OR COMPLETE BELOW INFORMATION IN FULL			
PRINT NAME OF INSURED /RESPONSIBLE PARTY (LAST, FIRST, MIDDLE), IF OTHER THAN PATIENT			
RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT			
STREET ADDRESS OF INSURED/RESPONSIBLE PARTY APT #			
CITY	STATE	ZIP	PHONE NO.
MEDICARE NUMBER			
MEDICAID NUMBER (Attach copy of eligibility form)			
INSURANCE CO. NAME			
MEMBER / INSURED ID #		GROUP #	
INSURANCE ADDRESS			
CITY	STATE	ZIP	
EMPLOYER NAME/EMPLOYER #		INSURED SOCIAL SECURITY # (If not patient)	
ICD9 DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)			

DATE COLLECTED	TIME	AM PM
TIME IN FORMALIN (FOR BREAST BIOPSY SPECIMENS)		
REFERRING PHYSICIAN AND NPI (MUST INCLUDE)		
NPI _____		
<input type="checkbox"/> Call Results to: () <input type="checkbox"/> Fax		
Send Duplicate Report to:		
CLIENT # OR NAME: _____		
ADDRESS: _____		
CITY: _____ STATE _____ ZIP _____		

INFORMATION BELOW IS IMPORTANT FOR PROPER INTERPRETATION

CLINICAL DIAGNOSIS: _____

PERTINENT CLINICAL HISTORY / OPERATIVE FINDINGS: _____

PREVIOUS SURGERY (IF EXAMINED AT THIS LAB INCLUDE PATHOLOGY NO.): _____

IF SKIN BIOPSY, TYPE OF BIOPSY:
 Punch Shave Incisional Excisional Excisional with margin examination
 SITE(S) OF BIOPSY (USE ONE REQUISITION PER PATIENT)

IF GYN SPECIMEN: LMP _____ PREVIOUS PAP DATE: _____

PREVIOUS BIOPSY OR PAP #: _____

- Check if Pap was submitted simultaneously with biopsy
- | | | |
|--|--|---|
| <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Post Menopausal |
| <input type="checkbox"/> Post Partum | <input type="checkbox"/> Post Abortion | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> DES Exposure | <input type="checkbox"/> IUD | <input type="checkbox"/> Hormonal Therapy (Specify below) |

ADDITIONAL INFORMATION: _____

- HPV Reflex for ASCUS LGSIL HGSIL
 HPV only-No Pap HPV for woman >30
 No HPV wanted Chlamydia GC

DID YOU REMEMBER...
 TO INCLUDE DIAGNOSIS CODE(S)?
 TO REQUEST OR MARK TEST(S)?

ONE OF THE FOLLOWING MUST BE CHECKED (REQUIRED)

- NON-Medicare Patient**
 Medicare Patient - Screening Pap; routine (reimbursable once every 2 years).
 Medicare Patient - Screening Pap; high risk of cervical cancer and physician recommends screening more often than every two years based on medical history (reimbursable once every year)
 Medicare Patient - Pap Smear, HPV, VD tests; history of abnormality or signs or symptoms of medical necessity, (appropriate ICD-9 codes must be listed in box above.)

MUST ATTACH ADVANCE BENEFICIARY NOTICE

F# _____

S# _____

M# _____

FOR OFFICE USE

SEND TOP 3 COPIES WITH SPECIMEN

DATE RECEIVED: _____

UT PATHOLOGY CASE #: _____