REQUEST FOR PATHOLOGY CONSULTATION

THE UNIVERSITY OF TEXAS
HEALTH SCIENCE CENTER AT HOUSTON
6431 Fannin, MSB 2.020, Houston, Texas 77030
1-855-4UTPATH (1-855-488-7284)

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: ☐ SELF ☐ SPOUSE ☐ 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)

ICD10 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 ____________

☐ Call ☐ Fax Results to: ( )

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
☐ Oral contraceptives ☐ Pregnant ☐ Post Menopausal
☐ Post Partum ☐ Post Abortion ☐ Abnormal Bleeding
☐ DES Exposure ☐ IUD ☐ Hormonal Therapy (Specify below)

ADDITIONAL INFORMATION: ____________

☐ HPV Reflex for ASCUS ☐ LGSIL ☐ HGSIL
☐ HPV only-No Pap ☐ HPV High Risk
☐ HPV 16/18 Reflex only ☐ Chlamydia/GC
☐ HSV 1 & 2 ☐ Trichomonas ☐ BD Affirm Panel

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**
F ☐ **Medicare Patient -** Screening Pap; routine (reimbursable once every 2 years).
F ☐ **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

DATE RECEIVED:

UT PATHOLOGY CASE #:

SEND TOP 3 COPIES WITH SPECIMEN

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UTHS-001 (09/2015)