INTEGRATED
PATHOLOGY

SCIENTIFIC DIAGNOSES AND LABORATORY SOLUTIONS

BREAST PATHOLOGY REQUISITION

RESET FORM

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Breast Cancer Awareness

CLIENT INFORMATION:

PATIENT INFORMATION

Patient Name: _____ (LAST, FIRST)
DOB: _____ Age: _____ Gender: ◯ Male ◯ Female
Street Address: _____
City: _____ State: _____ Zip Code: _____
Patient ID #: _____ SSN#: _____
Submitting Physician: _____
Patient Phone #: _____ Referring Physician: _____
Date of Collection: _____ Time of Collection: _____

BILLING INFORMATION

Please provide the current ICD-10 code(s): _____
Please complete billing information below or attach a separate sheet and a copy of insurance card with the necessary information:
Insurance Company State Name of Employer
_____
Policy No. Group No.
_____
Insurance Company Street Address City State Zip Code
_____
Name of Insured (if other than patient): _____
Patient's relationship to insured: ◯ Spouse ◯ Child ◯ Other, Explain
IP Pathologists may order additional testing based on medical necessity.

CLINICAL DATA

Previous surgery: ◯ Yes ◯ No Previous Therapy: ☐ Chemotherapy ☐ Radiation ☐ Hormonal therapy ☐ Other: _____
Previous biopsy: ◯ Yes ◯ No Imaging Studies: ☐ Mammogram ☐ Ultrasound ☐ MRI ☐ Other: _____
Previous diagnosis: ◯ Yes ◯ No --- If Yes, Specify diagnosis: _____

Additional Pertinent Medical History:

SPECIMEN

Specimen	Location	Right Side	Left Side	Type (Core Biopsy, Cyst, Aspirate, Ultrasound Core, etc.)
A		●	◯	
B		●	◯	
C		●	◯	
D		●	◯	
E		●	◯	
F		●	◯	

SPECIAL INSTRUCTIONS

IF POSSIBLE, INCLUDE PATIENT OR SPECIMEN MAMMOGRAM FOR RADIOLOGY/PATHOLOGY CORRELATION.

IPS USE ONLY: Received Date & Time: Assigned Case #: