

SURGICAL PATHOLOGY REQUISITION FORM

PATIENT INFORMATION (REQUIRED)

Name Last _____ First _____

Gender Male Female Date of Birth mm ____ / dd ____ / yyyy _____

Street _____

City _____ State _____ ZIP _____

MRN / Patient ID# _____

PHYSICIAN INFORMATION (REQUIRED)

Referring MD _____

Attending/Ordering MD _____

Account Information _____

SPECIMEN INFORMATION (REQUIRED)

Specimen ID: _____

Sent date mm ____ / dd ____ / yyyy _____

Collection date mm ____ / dd ____ / yyyy _____ Time _____ AM PM

Body site: _____

Procedure: Fine Needle biopsy Core biopsy Excisional biopsy
 Other(s): _____

For packaging conditions and the required specimen quantity per test, please check our website:
<https://www.siparadigm.com/physician-support/specimen-requirements>

BILLING INFORMATION (BOTH SIDES REQUIRED)

<input type="checkbox"/> Insurance	<input type="checkbox"/> Non-hospital/office patient
<input type="checkbox"/> Client	<input type="checkbox"/> Out-patient hospital
<input type="checkbox"/> Patient	<input type="checkbox"/> In-patient hospital Discharge Date <small>mm</small> ____ / <small>dd</small> ____ / <small>yyyy</small> _____
	<input type="checkbox"/> Independent ambulatory clinic/surgical center

Please attach an Advance Beneficiary Notice (ABN) for all Medicare patients Available at www.siparadigm.com

TESTING OPTIONS (REQUIRED)

Primary Pathologic Examination and Diagnosis

Additional Reflex Surgical Testing: Surgical pathologist selects clinically pertinent tests including Histology, Flow, FISH, Karyo, Immunohistopathology & Molecular based on patient's diagnosis and preceding test results

REQUIRED kindly attach clinical history and other applicable reports.

See website www.siparadigm.com/compendium/ for detailed panel content

ICD-10 Code (REQUIRED)

Diagnosis

Attach clinical notes, patient information, and insurance card (REQUIRED)

PHYSICIAN SIGNATURE (REQUIRED)

Confirmation of Informed Consent & Statement of Medical Necessity:
 I affirm each of the following: 1) Testing is medically necessary for the diagnosis of a disease or syndrome. 2) The results will be used in the patient's medical management and treatment decisions. 3) The person listed as the ordering physician is authorized by law to order the test(s) requested herein.

I am certified to order the test(s) listed below, such that these test(s) are medically necessary and I have obtained informed consent for the requested test(s) when pertinent.

Signature *(MANDATORY FOR TESTING - Results will be delayed if consent signature is missing) _____ Date _____

PATIENT SIGNATURE: (REQUIRED)

I, the undersigned, authorize the holding facility to release my pathology material (paraffin blocks, slides, pathology report, etc.) to siParadigm Diagnostic Informatics Laboratory for additional testing.

Patient's signature: _____