

SURGICAL PATHOLOGY REQUISITION FORM

PATIENT INFORMATION (REQUIRED)

Name Last _____ First _____
 Gender Male Female Date of Birth ____/____/____
 Street _____
 City _____ State _____ ZIP _____
 MRN / Patient ID# _____

Gender Identity:

Male Female

Ethnicity:

African-American Jewish-Ashkenazi Adopted Asian
 Caucasian/NW European Jewish-Sephardic Native American Hispanic
 Middle Eastern Unknown Asked but Unknown Other _____
 Non-Hispanic or Non-Latino Choose not to disclose

Race:

American Indian or Alaska Native Black or African American
 Asian Native Hawaiian or Other Pacific Islander White
 Other _____ Unknown Asked but Unknown Choose not to disclose

SPECIMEN INFORMATION (REQUIRED)

Specimen ID: _____
 Sent date ____/____/____
 Collection date ____/____/____ 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>

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

PHYSICIAN INFORMATION (REQUIRED)

Referring MD _____
 Attending/Ordering MD _____
 Account Information _____

BILLING INFORMATION (BOTH SIDES REQUIRED)

SPECIMEN COLLECTION LOCATION

Insurance Non-hospital/office patient
 Client Out-patient hospital
 Patient In-patient hospital Discharge Date ____/____/____
 Independent ambulatory clinic/surgical center

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

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: _____