siParadigm diagnostic informatics

USA 888-599-5227 / 201-599-9044
201-599-9066
888-890-4774 (Toll-free fax)

PR 888-782-5430
866-369-4114

Requisition Number: _____
Pick-up Confirmation # _____

☐ RUSH
☐ Call Results
☐ Need Results by: ___/___/___

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# _____

Gender Identity:

☐ Male ☐ Female ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Genderqueer, neither exclusively male nor female
☐ Additional gender category or other, please specify _____
☐ Choose not to disclose

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

Sexual Orientation:

☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Don't know
☐ Something else, please describe _____ ☐ 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 ___(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

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)

☐ Insurance
☐ Client
☐ Patient

SPECIMEN COLLECTION LOCATION

☐ Non-hospital/office patient
☐ Out-patient hospital
☐ In-patient hospital Discharge Date ___(mm) / ___(dd) / ___(yyyy)
☐ 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: _____