VITRO MOLECULAR
LABORATORIES

8700 W Flagler Street
Miami, FL 33174
Ph: (305) 267-7979
Fx: (786) 513-0175

BREAST REQUISITION FORM

EIN: 20-4506043 I **CLIA:** 10D1055514

Patient Information

Last	First	MI
DOB	Last 4 of SSN	☐ F ☐ M
Address		

City	State	ZIP	Phone

Physician Information

COPY TO	FAX

Insurance Information

☐ Bill to Insurance: Copy ID Cards Front & Back	☐ Bill Facility
Name of Carrier	Phone #
Carrier Address	
Policy #	Group / Plan #
Name of Insured (if not same as patient)	
DOB of Insured	Relationship to Patient

☐ SECONDARY INSURANCE EXISTS. IF CHECKED, PLEASE INCLUDE INSURANCE INFORMATION ON SEPARATE SHEET.

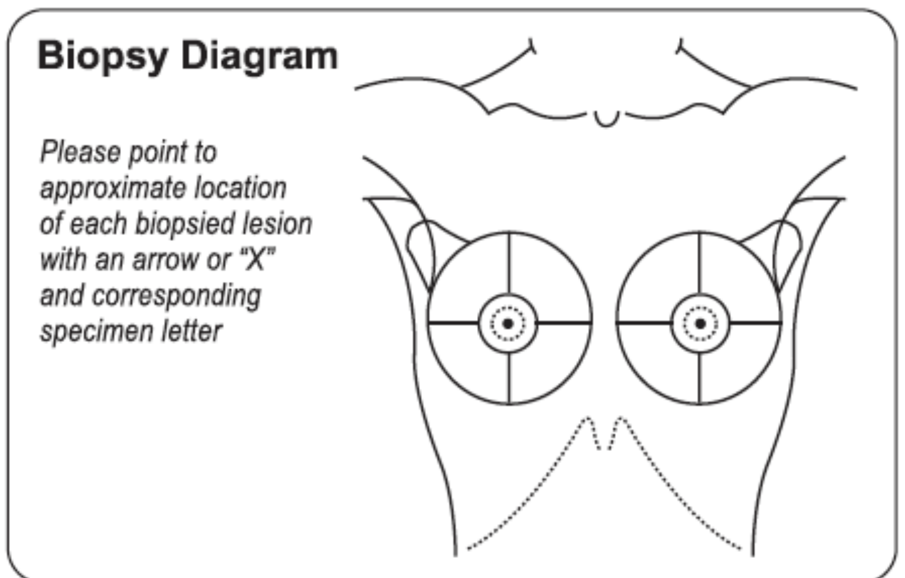
Name of Person Completing From	Authorization #
Date of Procedure	**ICD-9 Code (required)**

Clinical (and specimen) Information

	Laterality	Anatomic Location/Clinical Characteristics	Procedure	Gauge	Imaging Characteristics	BIRADS Category
A	☐ Right ☐ Left	________ O'Clock, ______ cm from nipple. Size ________ cm ☐ Palpable ☐ Non-palpable	☐ US-Bx ☐ MRI-Bx ☐ Stereo ☐ US-FNA		☐ Ca++ ☐ Density ☐ Enhancement ☐ Nodule	☐ 3 ☐ 4a ☐ 4b ☐ 4c ☐ 5
B	☐ Right ☐ Left	________ O'Clock, ______ cm from nipple. Size ________ cm ☐ Palpable ☐ Non-palpable	☐ US-Bx ☐ MRI-Bx ☐ Stereo ☐ US-FNA		☐ Ca++ ☐ Density ☐ Enhancement ☐ Nodule	☐ 3 ☐ 4a ☐ 4b ☐ 4c ☐ 5
C	☐ Right ☐ Left	________ O'Clock, ______ cm from nipple. Size ________ cm ☐ Palpable ☐ Non-palpable	☐ US-Bx ☐ MRI-Bx ☐ Stereo ☐ US-FNA		☐ Ca++ ☐ Density ☐ Enhancement ☐ Nodule	☐ 3 ☐ 4a ☐ 4b ☐ 4c ☐ 5
D	☐ Right ☐ Left	________ O'Clock, ______ cm from nipple. Size ________ cm ☐ Palpable ☐ Non-palpable	☐ US-Bx ☐ MRI-Bx ☐ Stereo ☐ US-FNA		☐ Ca++ ☐ Density ☐ Enhancement ☐ Nodule	☐ 3 ☐ 4a ☐ 4b ☐ 4c ☐ 5

Additional Clinical Info	**Nipple Discharge** ☐ Right ☐ Left	**H/O Prior Breast Cancer** ☐ Right ☐ Left
H/O ☐ Radiation Rx	H/O ☐ Chemo Rx	H/O ☐ Hormonal Rx
H/O ☐ Family H/O Breast CA		

Additional Info?



Testing Authorization

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION FOR THIS SERICE TO VITRO MOLECULAR. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO VITRO MOLECULAR OR ANY OF ITS AFFILIATES FRO SERVICES PERFORMED ON MY BEHALF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT REIMBURSED BY INSURANCE.

PHYSICIAN SIGNATURE	DATE
PATIENT SIGNATURE	DATE

NOTICE TO ORDERING PHYSICIAN: We respectfully ask that you, the ordering physician, authenticate your order for the pathologic examination of the accompanying specimen(s) by personally signing this requisition in the space provided, or by initialing next to your printed name. If your signature (or initials) is not affixed hereto, you attest that you have caused the subject patient's medical record to include a specific reference (i.e., order) to your intent that the accompanying specimen(s) be examined by a pathologist, and that you have personally signed (handwritten or electronic) said reference (i.e., order) in the subject patient's medical record.

PHYSICIAN SIGNATURE	DATE