VITRO MOLECULAR
LABORATORIES

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

GI REQUISITION

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

Patient Information

Last	First	MI
DOB	SSN	☐ F ☐ M
Address		
City	State / ZIP	Phone

Physician Information

Copy to:	Fax:

Billing

☐	Insurance	☐	Hospital non-patient
☐	Hospital in-patient	☐	Client Bill

Insurance Information (complete this section and/or use check boxes below)

Name of Carrier	Phone #
Carrier Address	
Policy #	Group/Plan #
Name of Insured (if not same as patient)	
DOB of Insured	Relationship to Patient
☐ SEE ATTACHED	☐ Secondary insurance exists. Please include a second sheet.

Name of Person Completing Form	Authorization #	Date Of Procedure:	Time of Procedure:	IDC-10 CODE:
		_____ / _____ / _____	_____ AM PM	

Endoscopic Findings & Procedure

Patient History and Reason for Endoscopy

☐ GERD	☐ HX OF CA _____
☐ ABDOMINAL PAIN	☐ HX OF POLYPS
☐ HEME - STOOL	☐ HX OF CROHN'S DISEASE
☐ DYSPEPSIA	☐ HX OF U.C.
☐ DIARRHEA	☐ SCREENING COLONOSCOPY
☐ CONSTIPATION	☐ CHANGE IN BOWEL HABITS
☐ BARRETT'S	☐ ANEMIA
☐ HEMATOCHEZIA	☐ RECTAL BLEED

OTHER _____

Please Rule Out

☐ ADENOMA / CA	☐ H. PYLORI
☐ BARRETT'S	☐ LYMPHOCYTIC COLITIS MICROSCOPIC
☐ CANDIDA	☐ COLITIS
☐ COLLAGENOUS COLITIS	☐ SPRUE
☐ CROHN'S	☐ ULCERATIVE COLITIS
☐ DYSPLASIA	☐ MOLECULAR

OTHER
_____
_____
_____

TEST REQUESTED

- ☐ HISTOPATHOLOGY
- ☐ CYTOPATHOLOGY-FLUID
- ☐ MMR (Mismatch repair proteins (immunohistochemistry)
- ☐ MSI (Molecular)
- ☐ KRAS
- ☐ EGFR
- ☐ OTHER _____

Specimen #	From	Site
	_____ CM	
	_____ CM	
	_____ CM	
	_____ CM	
	_____ CM	
	_____ CM	
	_____ CM	
	_____ CM	

Testing Authorization

I authorize that payment be made on my behalf to Vitro for any services furnished by them and also authorize Vitro to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to these services. If my health insurance plan will not direct payment to Vitro, I agree to forward Vitro all payments received for their services. I also authorize Vitro or any holder of medical information about me to release to my Health Insurance Plan such information needed to adjudicate their claim.

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**

MEDICAL RECORD #

TO ORDER SUPPLIES OR A SPECIMEN PICK UP PLEASE CALL (305) 267-7979 OR VISIT WWW.VITROMOLECULAR.COM