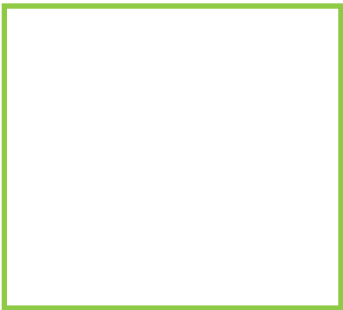




8700 W Flagler Street
Miami, FL 33174
Ph: (305) 267-7979
Fx: (786) 513-0175

HEAD & NECK PATHOLOGY REQUISITION

EIN: 20-4506043 | CLIA: 10D1055514



Patient Information			
Last	First	MI	
DOB	Last 4 of SSN	<input type="checkbox"/> F <input type="checkbox"/> M	
Address			
City	State	ZIP	Phone

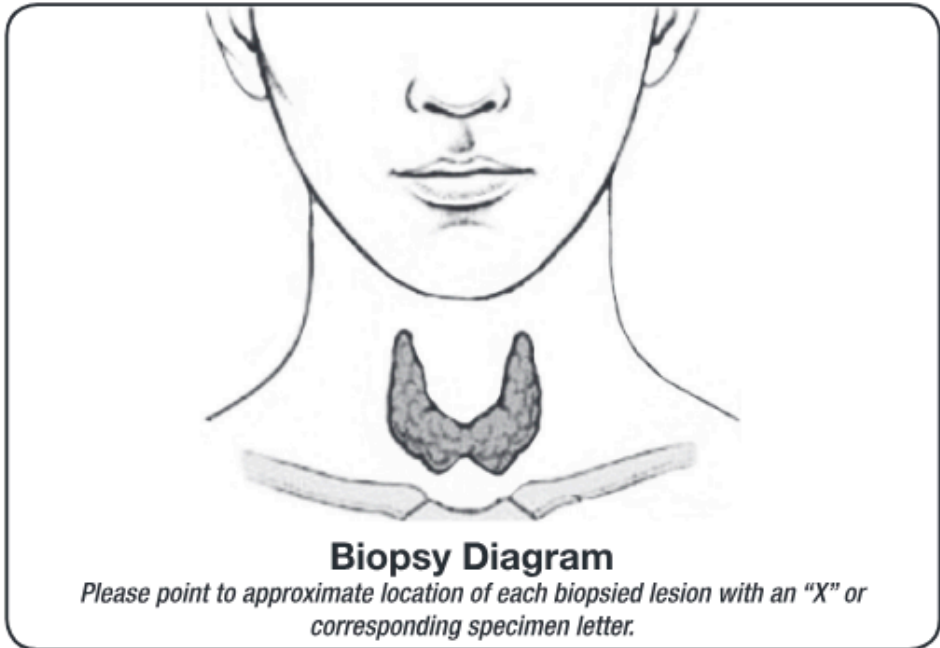
Physician Information	
Copy To	Fax

Testing Authorization	
<p><i>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.</i></p>	
PATIENT SIGNATURE	DATE

<p>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.</p>	
PHYSICIAN SIGNATURE	DATE

Clinical History	

Insurance Information	
<input type="checkbox"/> Bill to Insurance: COPY ID CARDS FRONT AND BACK	
<input type="checkbox"/> 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
<input type="checkbox"/> SECONDARY INSURANCE EXISTS. IF CHECKED, PLEASE INCLUDE INSURANCE INFORMATION ON SEPARATE SHEET	
Name of Person Completing Form	Authorization Number
Date Of Procedure: ____ / ____ / 20____	Time of Procedure: ____ <input type="checkbox"/> AM <input type="checkbox"/> PM
ICD Code:	



<input type="checkbox"/> Please perform thyroid molecular assays for indeterminate or reflective results <input type="checkbox"/> Please perform flow cytometry (send in RPMI holding media)

Specimen Source		Procedure						
A		<input type="checkbox"/> FNA	<input type="checkbox"/> Core Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Incisional Bx	<input type="checkbox"/> Other:
B		<input type="checkbox"/> FNA	<input type="checkbox"/> Core Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Incisional Bx	<input type="checkbox"/> Other:
C		<input type="checkbox"/> FNA	<input type="checkbox"/> Core Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Incisional Bx	<input type="checkbox"/> Other:
D		<input type="checkbox"/> FNA	<input type="checkbox"/> Core Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Incisional Bx	<input type="checkbox"/> Other:
E		<input type="checkbox"/> FNA	<input type="checkbox"/> Core Bx	<input type="checkbox"/> Punch Bx	<input type="checkbox"/> Shave Bx	<input type="checkbox"/> Excisional Bx	<input type="checkbox"/> Incisional Bx	<input type="checkbox"/> Other: