VITRO MOLECULAR
LABORATORIES

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

PODIATRY REQUISITION FORM

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

Patient Information

Last	First	MI

DOB	Last 4 of SSN	☐ F ☐ M

Address

City	State	ZIP	Phone

Physician Information

Copy To	Fax

Pertinent Clinical History

_____

_____

Insurance Information

☐ Bill to Insurance: COPY ID CARDS FRONT AND 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 Form	Authorization Number

Date Of Procedure: _____ / _____ / 20____	Time of Procedure: _____ ☐ AM ☐ PM

ICD Code:

SPECIMEN A: _____ ☐ Left ☐ Right

☐ Biopsy ☐ Excision ☐ Aspiration

SKIN

- ☐ Pigmented lesion (Rule out melanoma)
- ☐ Non-pigmented lesion (Verruca/R/O carcinoma)
- ☐ Dermatitis (Eczematous/Tinea)
- ☐ Ulceration (Malignancy/Vasculitis)
- ☐ Other

SOFT TISSUE

- ☐ Tumor (Ganglion/Lipoma/Sarcoma)
- ☐ Inflammatory (Tophus/Abscess)

BONE

- ☐ Arthritis (HAV/Hammer toe/DJD/Excostosis)
- ☐ Lytic/Destructive (Osteomyelitis/Neoplasm)

RULE OUT NEOPLASIA (All include histopathology)

- ☐ Pigmented lesion (R/O Melanoma)
- ☐ Non-pigmented lesion (Verruca/R/O carcinoma)

BACTERIOLOGY (Open Wound)

- ☐ Aerobic CX/Sensitivity/Gram
- ☐ Aerobic/Anaerobic Cx/Sensitivity/Gram

SPECIMEN B: _____ ☐ Left ☐ Right

☐ Biopsy ☐ Excision ☐ Aspiration

SKIN

- ☐ Pigmented lesion (Rule out melanoma)
- ☐ Non-pigmented lesion (Verruca/R/O carcinoma)
- ☐ Dermatitis (Eczematous/Tinea)
- ☐ Ulceration (Malignancy/Vasculitis)
- ☐ Other

SOFT TISSUE

- ☐ Tumor (Ganglion/Lipoma/Sarcoma)
- ☐ Inflammatory (Tophus/Abscess)

BONE

- ☐ Arthritis (HAV/Hammer toe/DJD/Excostosis)
- ☐ Lytic/Destructive (Osteomyelitis/Neoplasm)

RULE OUT NEOPLASIA (All include histopathology)

- ☐ Pigmented lesion (R/O Melanoma)
- ☐ Non-pigmented lesion (Verruca/R/O carcinoma)

BACTERIOLOGY (Open Wound)

- ☐ Aerobic CX/Sensitivity/Gram
- ☐ Aerobic/Anaerobic Cx/Sensitivity/Gram

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**

Notice to Patient

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**