Anatomic Pathology Consult Requisition

U I D L
U I Diagnostic Laboratories

ANATOMIC PATHOLOGY CONSULT REQUISITION

UI Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, Iowa 52242
Toll Free: 866-844-2522
Local: 319-384-7212
Fax: 319-384-7213

FOR CLIENT USE ONLY: Requisition Date:_____
Completed By: Accn#

FOR UIDL USE ONLY: UIDL Path #_____
UIDL MRN#

PART A - PATIENT INFORMATION - *Required*		
Patient Name:		
Street:		
City:	St:	Zip:
Phone: ( )		
Date of Birth:	Gender: ☐M ☐F	

PART B - PROVIDER INFORMATION - *Required*		
Referring Institution:		
Street:		
City:	St:	Zip:
Phone:	Fax:	
Referring Physician:		
Referring Physician NPI:		

PART C - SPECIMEN INFORMATION (Complete the appropriate information below or include in an accompanying letter.)

MATERIALS SUBMITTED: ____ **SLIDES*** ____ **BLOCKS*** ____ **WET TISSUE** ____ **FROZEN TISSUE** ____ **OTHER** Specify source below

Required ICD-9 codes: 1._____ 2._____ 3._____ 4._____ 5._____

TISSUE SOURCE/SITE: _____ **DATE OF COLLECTION:** _____

CONSULTATION REQUESTED: (All consultations include interpretation) *Please include a copy of your report*

☐ BONE MARROW/HEMATOLOGY
☐ CYTOPATHOLOGY
☐ DERMATOPATHOLOGY
☐ ELECTRON MICROSCOPY
☐ IMMUNOPATHOLOGY
☐ MOLECULAR PATHOLOGY
☐ NEUROPATHOLOGY
☐ RENAL PATHOLOGY
☐ SURGICAL PATHOLOGY

_____ _____
Physician signature **Date**

PERTINENT CLINICAL HISTORY AND FINDINGS: _____

CLINICAL DIFFERENTIAL DIAGNOSIS: _____

PREVIOUS TESTS RELEVANT TO CURRENT PROBLEM (e.g. Prior tissue, abnormal cytology examination, recent CBC, etc…)

LIST CYTOLOGY SPECIMENS AND COLLECTION METHOD (e.g. brush, wash, catheterized, void): _____

PART D - SEND BILL TO:

☐ **Referring Institution Contact:** _____
Address:
City, St, Zip code:
☐ **Patient's Insurance** (Complete billing information must be provided or referring institution may be billed)

Primary Insurance Coverage Information
Insured by: _____
Claims Address: _____
City :_____ST:___ ZIP:_____
Policy/ID #: _____ Group #: _____
Name of Subscriber: _____DOB:_____
Relationship to Patient:_____

Secondary Insurance Coverage Information
Insured by: _____
Claims Address: _____
City :_____ ST:_____ Zip: _____
Policy/ID #: _____ Group #: _____
Name of Subscriber: _____DOB:_____
Relationship to Patient: _____

Please note that the correct birth date of all policy holders is required information. Please attach the following to the requisition:

(1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage.
OR
(2) a printout with patient demographics and insurance information from your practice management system.

Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.

The purpose of this form is to obtain information necessary for UIDL Pathology Department to perform consultations and/or testing. Failure to properly complete the form may cause delay in the processing of specimens. *APR 05/08*