Southern Pathology

Knowledge from people who care

Sabaneta Industrial Park A-234 Ponce, P.R. 00716
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LAB. NUMBER:

BREAST HISTOPATHOLOGY REQUEST FORM

PATIENT INFORMATION

Patient Name: _____ Age: _____

Gender: ○F ○M DOB: __/__/__ (mm/dd/yy) SS No.: xxx-xx-_____ Phone No: (___) ___-____

Postal Address: _____

PHYSICIAN NAME:

_____

_____

BILLING INFORMATION (Please provide copy of insurance card and patient ID)

Bill to: ○Client ○Insurance ○Patient Health Insurance Name: _____ Insurance Contract No.: _____

Group No.: _____ Principal insured person: _____ DOB: __/__/__ (mm/dd/yy)

Work Place: _____ Relationship with patient: ○Self ○Spouse ○Child ○Other (specify): _____

CLINICAL INFORMATION

ICD-9/10 Codes: _____ Diagnosis under consideration: _____

Clinical History: _____

SPECIMEN SITE:

○ Mass
○ Calcifications
○ Mass with Calcifications
○ Asymmetric Density
○ Cyst
○ Cores CONTAIN CALCIUM
○ Cores DO NOT CONTAIN CALCIUM
○ Other: _____

COLLECTION DATE: __/__/__ (mm/dd/yy) COLLECTION TIME: __:__ AM PM TIME FIXATIVE ADDED: __:__ AM PM

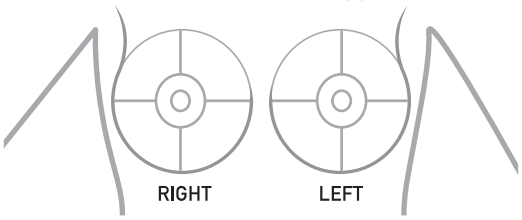
ADDITIONAL CLINICAL INFORMATION:

_____

_____

_____

PLEASE MARK THE BIOPSY SITE(S) WITH AN X



TEST REQUESTED

○ Breast Biopsy ○ Fluid Cytology ○ Fine Needle Aspiration Cytology ○ Other: _____

○ ER/PR ○ Ki-67 ○ P53 ○ Her2-Neu ○ Other: _____

○ If Positive for Carcinoma Perform Prognostic Biomarker (ER/PR, Ki-67, P53, Her2_neu)

SIGNATURES

Physician: _____ Date: __/__/__ (mm/dd/yy)

*Yo autorizo a mi médico a proveer información a Southern Pathology para propósitos de facturación a mi plan médico. De mi plan médico no cubrir la(s) prueba(s) de patología, me hago responsable del costo, ya sea del deducible o el costo total de la(s) prueba(s).• I authorize my physician to provide Southern Pathology with the necessary information to bill my Health Insurance for services rendered. I am responsible for the deductible and/or test(s) not covered by my Health Insurance.•

*Patient Name: _____ *Patient Signature: _____ Date: __/__/__ (mm/dd/yy)