VOPS dba PPS

Lab Use Only:
Tech Initial:
Accession #:______________________
Date/Time:______________________

GI PATHOLOGY REQUISITION

87256

PATIENT INFORMATION

Last Name	First Name	M.I.
Street Address	Apt. #	
City	State	Zip
Patient Phone Number	Patient Social Security Number	
Date of Birth / /	Age	Sex	Client ID #

BILLING / INSURANCE (or attach copy of insurance card - both sides)

☐ Bill Patient Insurance *(Attach copy of insurance card, both sides)*

☐ Bill Patient directly/No insurance ☐ Bill physician facility

ICD-10 CODE (Required)

SPECIMEN SITE

COMMENTS

ESOPHAGUS / STOMACH / DUODENUM

Bottle #								
Biopsy								
Polyp								
Esophagus								
Centimeter								
Cardia/Fundus								
Antral Body								
Body								
Antrum								
Duodenum 2nd								
Duodenum 3rd								
Other								

LARGE BOWEL / SMALL BOWEL

Bottle #								
Biopsy								
Polyp								
Ileum								
Ileocecal valve								
Cecum								
Ascending								
Hepatic Flexure								
Transverse								
Splenic Flexure								
Descending								
Sigmoid								
Rectum								
Other								

REV 12/16

CLIENT INFORMATION

Treating Physician	UPIN #

Physician's Signature X______________________

Send Duplicate of Report to:

Name ______________________

Address/Fax ______________________

COLLECTION INFORMATION

Date______________________ Time______________________

CLINICAL HISTORY (check all that apply)

☐ Family HX of Cancer
☐ HX of Cancer
☐ Anemia
☐ NSAID Usage
☐ HX of Barrett's Esophagus
☐ Dyspepsia
☐ Heartburn
☐ Reflux
☐ HX H. Pylori
☐ Nausea/Vomiting
☐ GERD
☐ Diarrhea
☐ Rectal Bleeding
☐ Bleeding
☐ Hem Pos Stool
☐ HX of Polyps
☐ HX Idiopathic Inflammatory Bowel Disease
☐ Other:______________________

POST-OPERATIVE DIAGNOSIS

COMMENTS

PRINT 7/17