MediPath
PATHOLOGY SERVICES
4665 Ponce De Leon Blvd., Coral Gables, FL 33146
Telephone 786-464-0749 • Fax 786-953-5342

BREAST REQUISITION

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PATIENT INFORMATION

LAST NAME	FIRST NAME	MI

DATE OF BIRTH	MRN/PT.CHART#	SEX ☐Male ☐Female

STREET ADDRESS

CITY	STATE	ZIP

HOME PHONE #	WORK PHONE #

CLIENT INFORMATION

LLC ACCOUNT #	NAME OF LLC	PHONE # FAX #

ORDERING PHYSICIAN / NPI #

CLIENT ADDRESS	CITY / STATE / ZIP

DATE COLLECTED	TIME COLLECTED ☐AM ☐PM

ICD-10 CODE(S):

SEND COPY OF RESULTS TO:

REFERRING PHYSICIAN: _____ PHONE #: _____

ADDRESS: _____ FAX #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	SECONDARY INSURANCE NAME

STREET ADDRESS	CITY / STATE / ZIP	STREET ADDRESS	CITY / STATE / ZIP

GROUP NUMBER	POLICY NUMBER	GROUP NUMBER	POLICY NUMBER

NAME OF POLICY HOLDER	NAME OF POLICY HOLDER

CLINICAL INFORMATION

☐Trauma ☐Nipple Inversion ☐Nipple Discharge ☐Skin Retraction ☐First degree family history of malignancy

☐History of malignancy: Type:_____ Side _____ Year _____ Treatment: ☐Chemo/Radiation Rx ☐Hormonal Rx

☐Other **clinical information**: _____

SAMPLE/SPECIMEN

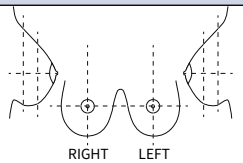
	SOURCE	SIDE	LESION INFORMATION	Collection Time	Time in Formalin	Ischemic Time	BI-RADs
A.		☐R ☐L	_____ O'Clock: _____ cm from the nipple ☐Calcifications ☐Mass: size _____ cm ☐Architectural Distortion ☐Asymmetry ☐Cyst / Fluid				☐2 ☐3 ☐4 ☐4A ☐4B ☐4C ☐5
B.		☐R ☐L	_____ O'Clock: _____ cm from the nipple ☐Calcifications ☐Mass: size _____ cm ☐Architectural Distortion ☐Asymmetry ☐Cyst / Fluid				☐2 ☐3 ☐4 ☐4A ☐4B ☐4C ☐5
C.		☐R ☐L	_____ O'Clock: _____ cm from the nipple ☐Calcifications ☐Mass: size _____ cm ☐Architectural Distortion ☐Asymmetry ☐Cyst / Fluid				☐2 ☐3 ☐4 ☐4A ☐4B ☐4C ☐5

PROCEDURE TYPE

Core Needle Biopsy: ☐US-Bx ☐MRI-Bx ☐Stereo ☐Not imaged guided

Biopsy/Excision: ☐Punch Biopsy ☐Shave Biopsy ☐Excisional Biopsy ☐Lumpectomy ☐Mastectomy

Cytology: ☐Nipple Discharge ☐Duct Brush/Washing ☐Fine Needle Aspiration (FNA)



Note: when ordering tests for which Medicare reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient.

Physician Signature: _____ **Date:** _____

A 000000000	B 000000000	C 000000000	D 000000000
Patient Name / D.O.B.	Patient Name / D.O.B.	Patient Name / D.O.B.	Patient Name / D.O.B.

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