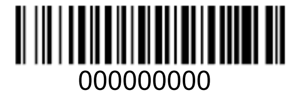
MediPath
PATHOLOGY SERVICES
4665 Ponce De Leon Blvd., Coral Gables, FL 33146
Telephone 786-464-0749 • Fax 786-953-5342

SURGICAL 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

DATE COLLECTED	TIME COLLECTED ☐ AM ☐ PM

ICD-10 CODE(S):

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

☐ Previous Abnormal biopsy / cytology and / or excision: result:________________________________

Treatment: ________________________________ ☐ Radiation / Chemotherapy ☐ Hormone Treatment

CURRENT PERTINENT CLINICAL INFORMATION:

☐ **Clinically Infection** ☐ **Polyps:** (☐ Multiple Single ☐ Polypoid ☐ Flat/ Sessile) ☐ **Skin lesion:** (☐ Pigmented ☐ Inflamed ☐ Ulcerated ☐ Hypopigmented)

☐ **Mass, location, dimension, features and characteristics:** ________________________________

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SAMPLE / SPECIMEN

SOURCE(S): ☐ Skin and Soft Tissue ☐ Lymph node ☐ Oral cavity Tonsils, Pharynx, Larys ☐ Upper GI: Esophagus, Stomach, Small bowel ☐ Colon: Appemdix, Cecum, Ascending, Descending, Sigmoid, Rectum, Anal canal ☐ Genital area / perineum ☐ Solid Organ: ____________________ ☐ Cyst ☐ Fat pad ☐ Nails ☐ Foreign body

PROCEDURE: ☐ Core Biopsy ☐ Punch biopsy ☐ Incisional biopsy ☐ Excision ☐ Removal/extraction/Passage ☐ Ectomy ☐ Piecemeal Ectomy / resection ☐ Ligation ☐ Rhaphy ☐ Curetting ☐ Clippings ☐ Fine needle aspiration: # of smears ________ ☐ Fluid aspiration ☐ Cytolyt

Laterality	Source	Specific Site	Histology	Cytology
A. ☐ Right ☐ Left			☐	☐
B. ☐ Right ☐ Left			☐	☐
C. ☐ Right ☐ Left			☐	☐
D. ☐ Right ☐ Left			☐	☐
E. ☐ Right ☐ Left			☐	☐
F. ☐ Right ☐ Left			☐	☐
G. Others:			☐	☐
H. Others:			☐	☐

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.
E 000000000	**F** 000000000	**G** 000000000	**H** 000000000
Patient Name / D.O.B.	Patient Name / D.O.B.	Patient Name / D.O.B.	Patient Name / D.O.B.