ALBANY MEDICAL CENTER HOSPITAL PATHOLOGY AND LABORATORY MEDICINE
43 New Scotland Avenue
Albany, New York 12208
(518) 262-5454

FOR INPATIENT USE ONLY

Patient Identification Plate

Collect Date: **Collect Time:**	**Location:**	**Initials:**

LIS Label

NOTIFICATION TO PHYSICIANS AND OTHER PERSONS LEGALLY AUTHORIZED TO ORDER TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT:

MEDICARE WILL ONLY PAY FOR TESTS THAT MEET THE MEDICARE COVERAGE CRITERIA AND ARE REASONABLE AND NECESSARY TO TREAT OR DIAGNOSE AN INDIVIDUAL PATIENT. MEDICARE DOES NOT PAY FOR TESTS FOR WHICH DOCUMENTATION, INCLUDING THE MEDICAL RECORD, DOES NOT SUPPORT THAT THE TESTS WERE REASONABLE AND NECESSARY. MEDICARE GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS EVEN IF THE PHYSICIAN OR OTHER AUTHORIZED PRACTITIONER CONSIDERS THE TESTS APPROPRIATE FOR THE PATIENT.

ICD 10 CODES/DIAGNOSIS:

REQUEST FOR SURGICAL PATHOLOGY TISSUE ANALYSIS

All of the following information is required by CLIA, The Joint Commission, and/or NY State Department of Health regulations:

Note specimen letter and write a source description for each one. Record the letter and source desciption on the specimen container.

Container Letter	Source Description	Container Letter	Source Description
A.		H.	
B.		I.	
C.		J.	
D.		K.	
E.		L.	
F.		M.	
G.		N.	

TOTAL # CONTAINERS: _____ ☐ Additional specimens for an existing case ☐ More specimens to follow

CLINICAL HISTORY (Include clinical data, previous pathology results, prior history or other pertinent information): OR ☐ **No pertinent clinical history**

PRE-OP DIAGNOSIS:

SURGICAL PROCEDURE:

Additional Comments: _____

☐ Infectious Material Please Specify: _____

Additional Information for OB/GYN: LNMP: _____ LMP: _____ GRAVIDA: _____ PARA: _____

PROCEDURE REQUESTED

☐ Routine Histology ☐ Electron Microscopy ☐ Immunofluorescent Studies ☐ Other Studies (specify) _____

Ordering practitioner: _____ (please print first and last names)

Ordering practitioner: _____ (signature)

Ordering practitioner contact #: _____

If ordering is PA, NP, or Resident:

Supervising physician is REQUIRED _____

Proceduralist (print): _____ (please print first and last names)

Proceduralist (signature): _____

Copy to (Physician): _____ (please print first and last names)

Copy to (Phone #): _____

Copy to (Fax #): _____

Copy to (Address): _____