Specimen collection Date: Time:	HIS Label	LIS Label

ALBANY MEDICAL CENTER

Department of Pathology

43 New Scotland Avenue
Albany, New York 12208
(518) 262-5454

Affix Arrival Label or Complete below:

NAME:	DOB:	SEX:
ADDRESS:		
GUARANTOR:	PHYSICIAN: **SEE BELOW**	
PRIMARY INSURANCE CO.:		
SUBSCRIBER:	RELATIONSHIP TO SUBSCRIBER:	
ID#	GROUP #:	
SECONDARY INSURANCE CO:	RELATIONSHIP TO SUBSCRIBER:	
SUBSCRIBER:	SUB. DOB:	SUB. SEX:
ID#:	GROUP #:	

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 description on the specimen container. If more than 12 containers being sent please use additional requisition. **Total # Containers** ______________

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

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

☐ Immunofluorescent Studies ☐ Chemical Composition Analysis (Stone)

☐ Routine Histology ☐ Electron Microscopy ☐ Other Studies (specify) ______________

Ordering practitioner: ______________ MD / PA / NP
print first and last name circle one

Copy To (Physician): ______________
print first and last name

Ordering practitioner: ______________ MD / PA / NP
signature circle one

Copy To (Phone #): ______________

Ordering practitioner contact #: ______________

If Resident then a Supervising : physician is REQUIRED ______________
print first and last name

Copy to (Fax #): ______________

Copy To (Address): ______________

Proceduralist (PRINT): ______________

Proceduarlist (Signature): ______________

OUTPATIENT