GI PATHOLOGY REQUISITION

Newport Harbor Pathology Medical Group

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PATIENT INFORMATION

Last Name First Name MI

Date of Birth M F Sex Patient Cell Phone Number

Patient Social Security Number Patient Home Phone Number

Street Address Apt #

City State Zip

BILLING INFORMATION: Attach copy of all insurance I.D. Cards (FRONT and BACK please.)

BILL TO: Patient ___ Doctor ___ HMO ___ Client ___ Medicare ___ Medi-cal Auth# _____	Insured's NAME: Relationship to Insured: ___ Self _____ Spouse _____ Dependent _____ Other	Insurance Company Name: Address:
Subscriber ID #:	Subscriber Date of Birth:	City:
Subscriber Group #:	Subscriber Sex: _____ Male _____ Female	State: Zip:

Medicare patient reviewed and signed Advanced Beneficiary Notice for Non-Covered Services

CLINICAL HISTORY

[ ] Cancer Screening
[ ] GI bleed
[ ] Anemia
[ ] Reflux
[ ] Barrett's
[ ] Dysphagia
[ ] Upper GI bleeding
[ ] Abdominal Pain
[ ] Bloating
[ ] Nausea/Vomiting
[ ] Diarrhea
[ ] Malabsorption
[ ] Lower GI bleeding
[ ] History of UC
[ ] History of Crohn's
[ ] History of polyps
[ ] History of Cancer
[ ] Other

ENDOSCOPIC FINDINGS

Esophagus
[ ] Normal
[ ] Esophagitis
[ ] Irregular Z-line
[ ] Barrett's mucosa
[ ] GE junction@____cm
[ ] Polyp
[ ] Mass
[ ] Ulcer
[ ] Other _____

Stomach
[ ] Normal
[ ] Erythema
[ ] Gastritis
[ ] Polyp
[ ] Mass
[ ] Ulcer
[ ] Other _____

Duodenum
[ ] Normal
[ ] Inflamed
[ ] Polyp
[ ] Mass
[ ] Ulcer
[ ] Other _____

Terminal Ileum/IC valve
[ ] Normal
[ ] Inflamed
[ ] Polyp
[ ] Mass
[ ] Ulcer
[ ] Other _____

Colon
[ ] Normal
[ ] Inflamed
[ ] Polyp
[ ] Multiple polyps
[ ] Mass
[ ] Ulcer
[ ] Other _____

Rectum/Anus
[ ] Normal
[ ] Proctitis
[ ] Polyp
[ ] Mass
[ ] Ulcer
[ ] Hemorrhoids
[ ] Other _____

ICD9 - DIAGNOSIS

Indication for Biopsy:

ORDERING PHYSICIAN NAME:

NPI NUMBER:

REPORT COPIES TO:

SPECIMENS:

1	5
2	6
3	7
4	8

DATE Collected: _____ **Time Collected:** _____ **COLLECTOR'S NAME** _____