NewPath Labs

Newport Harbor Pathology Medical Group, Inc.

BREAST PATHOLOGY REQUISITION

NEWPATH LABS

Newport Harbor Pathology Medical Group
2901 W. Coast Hwy., Suite 200, Newport Beach, CA 92663
Telephone: 949-891-1297 FAX: 949-625-8010 www.newpathlabs.com

CASE # _____
For Lab Use Only

*** HIGHLIGHTED AREAS ARE REQUIRED**

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Date of Birth _____ M F Sex _____ Patient Social Security Number _____

Patient Cell Phone 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 ❑ Ins. ❑ Client ❑ Medicare ❑ Medi-cal		Insured's Name:		Insurance Company Name:	
Auth#		Relationship to Insured: ❑ Self ❑ Spouse ❑ Dependent ❑ Other		Address:	
ID#:	Group#:	Insured's Date of Birth:	Insured's Sex: ❑ Male ❑ Female	City	State/Zip

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

HISTORY AND CLINICAL INFORMATION

BIOPSY SITE:

☐ RIGHT BREAST ☐ LEFT BREAST
☐ RIGHT AXILLA ☐ LEFT AXILLA
☐ OTHER _____

LOCATION IN BREAST: _____

PROCEDURE:

☐ Stereotactically Guided Core Biopsy
☐ Ultrasound Guided Core Biospy
☐ MRI Guided Core Biopsy
☐ OTHER _____

INDICATION FOR BIOPSY

☐ Smooth mass ☐ Architectural distortion ☐ Casting type Ca^{++}
☐ Irregular mass ☐ Intraductal lesion ☐ Diffuse Ca^{++}
☐ Asymmetric density ☐ Abnormal lymph node ☐ Grouped Ca^{++}
☐ Complex lesion ☐ Palpable mass ☐ MRI Lesion
☐ Number of Samples _____
☐ OTHER _____

DIAGNOSIS CODE / REASON FOR PROCEDURE:

ORDERING PHYSICIAN NAME:

FACILITY:

REPORT COPIES TO:

DATE COLLECTED: _____ **TIME COLLECTED:** _____ **COLLECTOR'S NAME** _____