ACUPATH LABORATORIES, INC
TEL # 1-888-"ACUPATH" (228-7284)
TEL # (516) 775-8103
FAX # (516) 326-3452
28 S. TERMINAL DRIVE, PLAINVIEW, NY 11803
WWW.ACUPATH.COM
"FOR THE ABSOLUTE HIGHEST STANDARD IN PLASTIC SURGERY PATHOLOGY" © 2020

PLASTIC SURGERY TEST REQUEST FORM

PL003BL

ANY OMISSION MAY RESULT IN DELAY OF REPORT

NOT FOR PATIENT USE

PHYSICIAN SIGNATURE_____

DUPLICATE REPORT TO:_____

COMMENTS TO PRINT OUT ON REPORT:_____

CHECK MARGINS ☐ **DATE OBTAINED:**___/___/___

STAT ☐ OTHER_____

CALL MD W/RESULTS ☐ CONSULTATION ☐

ICD-10_____

BIOPSY METHOD: ☐ PUNCH ☐ EXCISIONAL ☐ INCISIONAL
☐ SHAVE ☐ CURETTE ☐ SNIP ☐ CAUCERIZATION ☐ LASER

TEST REQUEST: HISTOPATHOLOGY

DIF (DIRECT IMMUNOFLUORESCENCE) CHECK APPROPRIATE BOX

☐ PREVIOUS BIOPSY_____

☐ # OF SPECIMEN BOTTLES_____ SLIDES_____ BLOCKS_____

BIOPSY SITE	DIF	RPMI FLOW	DURATION / HISTORY / CLINICAL DIAGNOSIS
☐ *Perform Cytospin if necessary*			
A			
B			
C			
D			
E			
F			

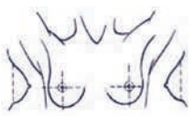
BREAST TISSUE PATHOLOGY

DIAGNOSTIC, PROGNOSTIC AND THERAPEUTIC ANALYSIS

☐ ER/PR ☐ Her2/neu by (IHC) ☐ Ki67

☐ Her2/neu (IHC) Reflex to Her2/neu by FISH, PathVysion™
If ☐ 1+ ☐ 2+ ☐ 3+

☐ OTHER:_____



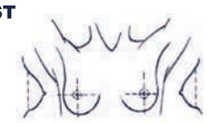
R☐ L☐

NON-GYNECOLOGIC: CYTOLOGY TEST REQUEST

***Breast Cytology*:**

☐ NIPPLE DISCHARGE FLUID ___R ___L

☐ FINE NEEDLE ASPIRATION (FNA) ___R ___L



R☐ L☐

PATIENT INFORMATION RACE (optional)

SS# + + DATE OF BIRTH M☐ F☐

LAST NAME FIRST NAME M.I.

STREET ADDRESS

CITY STATE ZIP

TEL. # CHART # PATH #

PATIENT'S PRIMARY INSURANCE

BILL TO: ☐ MEDICARE ☐ PATIENT ☐ OTHER ☐ NO FAULT ☐ WORKERS COMP

INSURED'S NAME_____ D.O.B.___/___/___

DATE OF ACCIDENT (IF NO FAULT/WORKERS COMP)___/___/___

PT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

POLICY #_____ SS #_____

GROUP NAME/#_____

NAME OF INSURANCE CO._____

INSURANCE ADDRESS_____

CITY_____ STATE_____ ZIP_____

SECONDARY INSURANCE

INSURED'S NAME_____ D.O.B.___/___/___

PT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

POLICY #_____ SS #_____

GROUP NAME/#_____

NAME OF INSURANCE CO._____

INSURANCE ADDRESS_____

CITY_____ STATE_____ ZIP_____

I authorize the release to my insurance carrier of any medical information necessary to process this claim, and I authorize payment of medical benefits directly to Acupath Laboratories, Inc. I understand that if I do not have insurance, I will be billed directly by Acupath Laboratories, Inc.

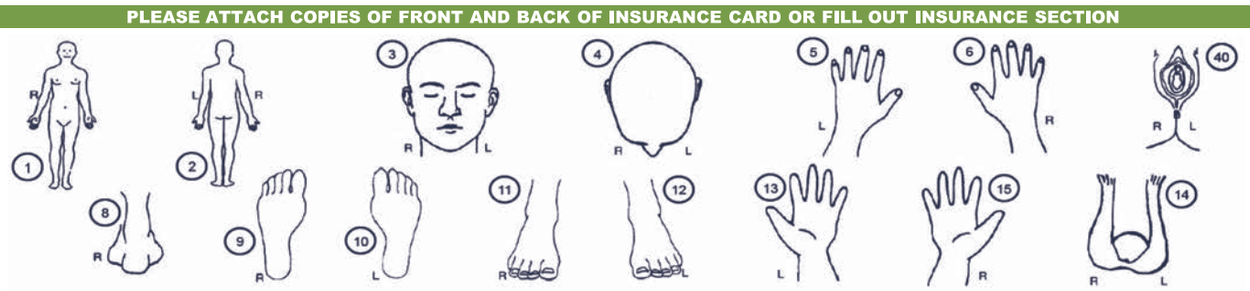
I also authorize release of my pathology results to my doctor utilizing all methods of transmission according to HIPAA regulations.

Patient Signature_____

CLINICAL DATA (Required)_____

DISCLAIMER: De-identified patient data may be used for R & D purposes.

PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD OR FILL OUT INSURANCE SECTION



Remove labels and affix to specimen bottles and bag.
(1 label per bottle, 1 label for bag)

AFFIXED LABEL

AFFIXED LABEL

LABORATORY COPY