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

SURGICAL PATHOLOGY TEST REQUEST FORM

SP001BKL

ANY OMISSION MAY RESULT IN DELAY OF REPORT

PHYSICIAN SIGNATURE: _____

DUPLICATE REPORT TO: _____

COMMENTS TO PRINT OUT ON REPORT: _____

STAT ☐ **DATE OBTAINED:** ___/___/___ **TIME OBTAINED:** ___:___ AM PM

☐ CHECK MARGINS ☐ CONSULTATION

☐ CALL MD W/ RESULTS ☐ OTHER: _____

OF BOTTLES: _____ PREVIOUS BX: _____

OF SLIDES: _____ **ICD-10:** _____

COLLECTION METHOD: ☐ PUNCH ☐ EXCISION ☐ INCISIONAL ☐ CORE
☐ ASPIRATION ☐ VACUUM ASSISTED CORE ☐ STEREOTACTIC BIOPSY
☐ RADIOLOGICALLY GUIDED BIOPSY ☐ OTHER _____

☐ **FLOW CYTOMETRY (Use RPMI media for tissue)**

FISH (Fluorescence In Situ Hybridization) TESTING:
☐ *Acu*Probe™ **Melanoma** (for Melanoma confirmation)
☐ *Acu*Probe™ **Spitz** (for Spitz nevus confirmation)

MOLECULAR TESTING:
☐ HPV – TISSUE *If Screen Positive, Subtypes (6/11, 16/18, 31/33) are performed*

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

***Head and Neck Cytology*:** **FNA**

THYROID: ☐ RT ☐ LT Nodule/Mass Size: _____ ☐

LYMPH NODE: ☐ RT ☐ LT Nodule/Mass Size: _____ ☐

SALIVARY GLAND: ☐ RT ☐ LT Nodule/Mass Size: _____ ☐

SOFT TISSUE SITE: _____ Size: _____ ☐

OTHER SITE: _____ Size: _____ ☐

CLINICAL DATA *(Required)* _____

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 _____

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

BREAST PATHOLOGY / CYTOLOGY TEST REQUEST

***Breast Tissue Pathology*:**

DIAGNOSTIC, PROGNOSTIC AND THERAPEUTIC ANALYSIS

☐ ER/PR ☐ Her2/neu by (IHC) ☐ Ki67

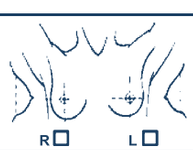
☐ Her2/neu (IHC), Reflex to Her2/neu by FISH, PathVysion™ if ☐ 1+ ☐ 2+ ☐ 3+

☐ OTHER: _____

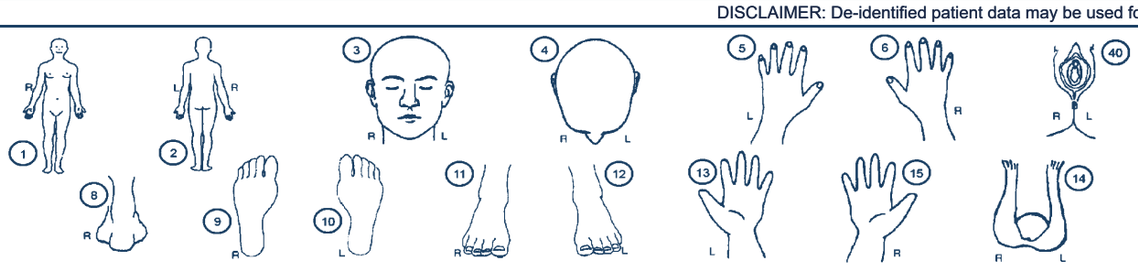
***Breast Cytology*:**

☐ NIPPLE DISCHARGE FLUID ___R ___L

☐ FINE NEEDLE ASPIRATION (FNA) ___R ___L



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



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

A _____	C _____	E _____
B _____	D _____	F _____

V082922

LABORATORY COPY