REQUISITION FORM

Gastrointestinal Pathology

EastPath Diagnostics
www.eastpathdx.com

EastPath Diagnostics, LLC
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Bayside, NY 11361
Tel: 718-279-1271 Fax: 718-279-1092

PART A: Patient Information - ***Required***

Patient Name:_____

Date of Birth_____ Gender M____F____

Address:_____

Phone Number:_____

Social Security:_____EMR#_____

Specimen collection date:_____

PART B: Provider Information - ***Required***

Physician:_____

Address: _____

_____

Phone:_____ Fax:_____

NPI#_____Signature_____

Send Duplicate Report to: Name_____ Address/Fax_____

PART C: Indications/Clinical History: _____

Endoscopic Findings (ICD-9 Code) - ***Required***

Esophagus	Stomach	Duodenum/Small Bowel	Colorectal
[ ] ? Barrett's (530.85)	[ ] gastritis (535.5)	[ ] ?celiac/sprue/atrophy	[ ] colitis (558.9) [ ] Skip areas
[ ] erosion (530.89)	[ ] erosion (530.89)	[ ] inflamed (558.9)	[ ] erosion
[ ] esophagitis (530.10)	[ ] ulcer (531.9)	[ ] erosion (532.9)	[ ] hematochezia (578.1)
[ ] hiatal hernia (553.3)	[ ] atrophic (535.1)	[ ] ulcer (532.9)	[ ] inflamed (558.9)
[ ] stricture	[ ] mass (239)	[ ] polyp(s) (211.2)	[ ] mass (239)
[ ] thickened mucosa	[ ] polyp(s) (211.1)	[ ] mass (239)	[ ] polyp(s) (211.3)
[ ] ulcer	[ ] xanthoma	[ ] ? Crohn's (555.9)	[ ] ulcerations (569.82)
[ ] ? fungal	[ ] other_____	[ ] ? Parasite_____(129)	[ ] ulcerative colitis (556.9)
			[ ] ? Crohn's (555.9)
			[ ] ? Ischemia (557.9)

PART D: Insurance Billing Information: *Send Bill to:* Patient:____ Insurance:____

Medicare:_____Insurance:_____ Self Pay:_____ Relation to Insured:_____

Insured Name:_____ Insured I.D._____Group #:_____

Please Attach: A copy of the front/back of patient's insurance card(s) and/or demographics

PART E: Specimen Information: # of Container:_____

Esophagus:
_____ Esophagus
_____ G-E Junction
_____ Barrett's
_____ Distal
_____ Mid
_____ Proximal
_____ Ulcer
_____ ? Fungus
_____ ? Viral

Stomach:
_____ Antrum
_____ Body
_____ Fundus
_____ Cardia
_____ Pylorus
_____ Polyp
_____ Mass
_____ Ulcer
_____ H. pylori gastritis

Duodenum/Small bowel
_____ Duodenum
_____ 2nd Portion of Duodenum
_____ Duodenal Bulb
_____ Ampulla of Vater
_____ Jejunum
_____ Ileum
_____ Terminal Ileum

Cecum/Colorectal:
_____ cecum
_____ ascending
_____ ileocecal valve
_____ hepatic flex ___cm
_____ transverse ___cm
_____ splenic flexure ___cm
_____ descending ___cm
_____ sigmoid ___cm
_____ rectosigmoid ___cm
_____ rectum _____cm

FOR LAB USE ONLY: Receiving Date:_____Time:_____Accession#_____Note_____