Specimen collection Date: Time:	HIS Label	LIS Label

ALBANY MEDICAL CENTER

Department of Pathology

43 New Scotland Avenue
Albany, New York 12208
(518) 262-5454

Affix Arrival Label or Complete below:

NAME: DOB: SEX:

ADDRESS:

GUARANTOR: PHYSICIAN: **SEE BELOW**

PRIMARY INSURANCE CO.:

NOTIFICATION TO PHYSICIANS AND OTHER PERSONS LEGALLY AUTHORIZED TO ORDER TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT:

MEDICARE WILL ONLY PAY FOR TESTS THAT MEET THE MEDICARE COVERAGE CRITERIA AND ARE REASONABLE AND NECESSARY TO TREAT OR DIAGNOSE AN INDIVIDUAL PATIENT. MEDICARE DOES NOT PAY FOR TESTS FOR WHICH DOCUMENTATION, INCLUDING THE MEDICAL RECORD, DOES NOT SUPPORT THAT THE TESTS WERE REASONABLE AND NECESSARY. MEDICARE GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS EVEN IF THE PHYSICIAN OR OTHER AUTHORIZED PRACTITIONER CONSIDERS THE TESTS APPROPRIATE FOR THE PATIENT.

SUBSCRIBER: RELATIONSHIP TO SUBSCRIBER:

ID# GROUP #:

SECONDARY INSURANCE CO: RELATIONSHIP TO SUBSCRIBER:

SUBSCRIBER: SUB. DOB: SUB. SEX:

ID#: GROUP #:

ICD 10 CODES/DIAGNOSIS:

REQUEST FOR SURGICAL PATHOLOGY TISSUE ANALYSIS

All of the following information is required by CLIA, the Joint Commission, and/or NY State Department of Health regulations:

Note specimen number and write a source description for each one. Record the number and source description on the specimen container.
If more than 12 containers being sent please use additional requisition. **Total # Containers** _____

Container Letter	Source Description	Container Letter	Source Description
A.		G.	
B.		H.	
C.		I.	
D.		J.	
E.		K.	
F.		L.	

CLINICAL HISTORY (Include clinical data, previous pathology results, prior history or other pertinent information): OR ☐ **No pertinent clinical history**

PRE-OP DIAGNOSIS:

SURGICAL PROCEDURE:

Additional Comments: _____

☐ Infectious Material Please Specify: _____

Additional Information for OB/GYN: LNMP: _____ LMP: _____ GRAVIDA: _____ PARA: _____

PROCEDURE REQUESTED

☐ Routine Histology ☐ Immunofluorescent Studies ☐ Electron Microscopy ☐ Chemical Composition Analysis (Stone) ☐ Other Studies (specify) _____

Ordering practitioner: _____ MD / PA / NP
print first and last name — circle one

Copy To (Physician): _____
print first and last name

Ordering practitioner: _____ MD / PA / NP
signature — circle one

Copy To (Phone #): _____

Ordering practitioner contact #: _____

If ordering is PA, NP, or Resident:
Supervising physician is REQUIRED _____
print first and last name

Copy to (Fax #): _____

Copy To (Address): _____

Proceduralist (PRINT): _____

Proceduarlist (Signature): _____