SEPA Labs
SOUTHEASTERN PATHOLOGY ASSOCIATES

Anatomical Pathology Requisition

Phone: (888) 261-2671 www.sepalabs.com

CAP ACCREDITED

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PATIENT INFORMATION

Service Date: _____ Time Collected: _____ Ordering Physician: _____

Name (last, first, middle): _____

DOB: ___ / _____ / _____ Gender: ☐ M ☐ F SSN: _____ - _____ - _____

Address: _____ City: _____ Zip: _____

Contact Phone : (_____) _____ - _____ x _____

Responsible Party: Relationship:

ORDERING PHYSICIAN/FACILITY

BILLING INFORMATION

(Please attach patient face sheet and front and back of insurance card to ensure correct billing)

☐ Medicare ☐ Medicaid ☐ Client ☐ Patient ☐ Other (see attached)

Primary Insurance Name

Policy #:

Group #:

Secondary Insurance Name

Policy #:

Group #:

Patient/Chart # Date

ICD-9/10 Diagnosis Code(s)

Please provide a diagnosis code for all tests ordered that can be substantiated by the patient's medical record. Tests deemed not "MEDICALLY NECESSARY" must be accompanied by a signed ADVANCE BENEFICIARY NOTICE (ABN).

*PROVIDING A SOCIAL SECURITY # & DATE OF BIRTH IS ESSENTIAL TO LOCATE AND REVIEW PREVIOUS HISTOLOGY AND CYTOLOGY

Procedure:

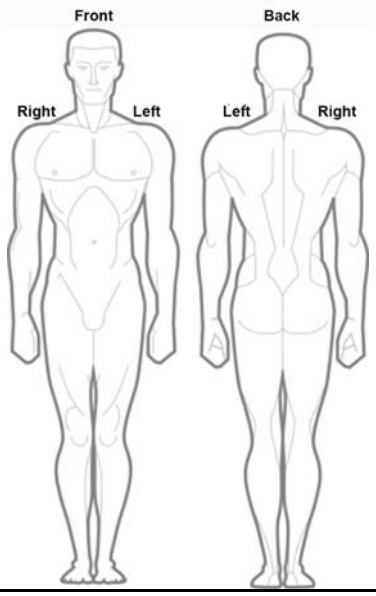
Clinical Information: ***(please complete)***

Special Requests: Frozen Sections ☐ Flow Cytometry ☐ Non-Gyn Cytology ☐ Other ☐ Micro *(Sent to outside lab)* ☐

Non-Gynecologic Cytology

☐ Abdominal Fluid (Vol) _____
☐ Peritoneal Fluid (Vol) _____
☐ Breast Aspirate ☐ L ☐ R
☐ Breast Secretion ☐ L ☐ R
☐ Bronchus ☐ L ☐ R ☐ Aspirate ☐ Brushing ☐ Washing
☐ Misc Fluid (Source) _____
☐ Pleural Fluid ☐ L ☐ R (Vol) _____
☐ Thyroid FNA ☐ L ☐ Isthmus ☐ R
☐ Urine ☐ Voided ☐ Cath ☐ Bladder Washings
☐ FISH ☐ Reflex FISH if atypical
☐ Fine Needle Aspirate (Source) _____
☐ Misc Smear (Source) _____

Materials Submitted:



(Required for Non-Cytology Breast Pathology)

Time of Excision: . AM / PM

Time in Formalin: AM / PM

AFFIX LABEL HERE

P.E.T. Godbey, M.D., FCAP, MEDICAL DIRECTOR