

## Pathology Solutions



Accession - Lab Use Only

**COLLECTION DATE:**
 **STAT or RUSH**

GI00001

**PATIENT INFORMATION**

LAST NAME	FIRST NAME	MI
DATE OF BIRTH MM / DD / YYYY	MRN # / PAT. CHART #	
SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
STREET ADDRESS		
CITY/STATE/ZIP		
HOME PHONE NUMBER	WORK PHONE NUMBER	

**CLIENT INFORMATION**

Referring Physician: _____	
COPIES TO: _____	
SECONDARY INSURANCE	
CITY/STATE/ZIP	
POLICY #	GROUP #
GROUP EMPLOYER	
NAME OF POLICY HOLDER	

**INSURANCE INFORMATION**
 BILL TO INSURANCE: COPY ID CARD(S) FRONT & BACK OR COMPLETE BELOW  
 BILL PATIENT  BILL PHYSICIAN  
 PRIMARY INSURANCE  
 CITY/STATE/ZIP  
 POLICY # GROUP #  
 MEDICARE NUMBER  
 GROUP EMPLOYER  
 NAME OF POLICY HOLDER

**CLINICAL DATA** Symptoms, Signs and History (Check all that apply)

<input type="checkbox"/> Anorexia	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Reflux	<input type="checkbox"/> Personal History of Cancer (Type) _____
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Hem. Positive Stool	<input type="checkbox"/> Screening	<input type="checkbox"/> Personal History of Idiopathic Inflammatory Bowel Disease
<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Iron Deficient Anemia	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Personal History of Lymphoma
<input type="checkbox"/> Diarrhea (Bloody)	<input type="checkbox"/> Microscopic Colitis	<input type="checkbox"/> Family History of Cancer (Type) _____	<input type="checkbox"/> Personal History of Polyps
<input type="checkbox"/> Diarrhea (Watery)	<input type="checkbox"/> Nausea	<input type="checkbox"/> Family History of H. Pylori	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dyspepsia	<input type="checkbox"/> NSAID Usage	<input type="checkbox"/> Family History of Barrett's Esophagus	
<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Pain (Type) _____	<input type="checkbox"/> Personal History of Barrett's Esophagus	

**ANATOMIC SITE**

UPPER GI Specimen		Anatomic Site										Endoscopic Findings (See Codes below)
#	From	Esophagus	EG Junction	Fundus	Body	Antrum	Duodenum (Adult)	Duodenum (Small)	Proximal	Distal	Other (Specify)	
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**SPECIAL INDICATIONS** (Check all that apply)

<input type="checkbox"/> Colitis Surveillance Colonoscopy	<input type="checkbox"/> Rule Out Fungi
<input type="checkbox"/> Polyp/Neoplasm Surveillance Colonoscopy	<input type="checkbox"/> Rule Out Gastritis/H. Pylori
<input type="checkbox"/> Rule Out Barrett's Esophagus	<input type="checkbox"/> Rule Out Idiopathic IBD
<input type="checkbox"/> Rule Out Cancer	<input type="checkbox"/> Rule Out Microscopic Colitis
<input type="checkbox"/> Rule Out Candida	<input type="checkbox"/> Rule Out Parasites
<input type="checkbox"/> Rule Out Crohn's	<input type="checkbox"/> Rule Out Sprue
<input type="checkbox"/> Rule Out Dysplasia	<input type="checkbox"/> Rule Out Viral Inclusions
<input type="checkbox"/> Rule Out Eosinophilic Esophagitis	<input type="checkbox"/> Rule Out Ulcerative Colitis
<input type="checkbox"/> Rule Out (Other) _____	

**LOWER GI Specimen**

#	From	Ileum	Cecum	Ascending	Hepatic Flexure	Transverse	Splenic Flexure	Descending	Sigmoid	Rectum	Proximal	Mid	Distal	Other (Specify)	Endoscopic Findings (See Codes below)
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

**OTHER TESTS**

--

**BIOPSY DATA** (A box **MUST** be checked in order to perform testing)

 Histology  Cytology (Brushings)  
 Consultation: On referred slides\*  
 Consultation: Referred material requiring slide prep\*  
 \*Please send pathology reports with all consultations

**ENDOSCOPIC CODES**

Please write the applicable number(s) for each corresponding biopsy specimen in the Anatomic Site section above. (Do not circle code numbers)

- |                    |               |                 |              |              |                   |              |                |
|--------------------|---------------|-----------------|--------------|--------------|-------------------|--------------|----------------|
| 1 Barrett's Mucosa | 3 Erythema    | 5 Hiatal Hernia | 7 Nodularity | 9 Polyp      | 11 Pseudomembrane | 13 Ulcer     | 15 Random bx   |
| 2 Erosion          | 4 Granularity | 6 Mass          | 8 Normal     | 10 Polyposis | 12 Stricture      | 14 H. Pylori | 16 Other _____ |

Physician's Signature (required): \_\_\_\_\_

Date: \_\_\_\_\_

246 INDUSTRIAL WAY WEST, SUITE 2 • EATONTOWN, NJ 07724 • P 732.389.5200 / F 732.389.5299

 Pathology Solutions GI00001-1 Patient Name: _____ Site 1: _____	 Pathology Solutions GI00001-2 Patient Name: _____ Site 2: _____	 Pathology Solutions GI00001-3 Patient Name: _____ Site 3: _____	 Pathology Solutions GI00001-4 Patient Name: _____ Site 4: _____
 Pathology Solutions GI00001-5 Patient Name: _____ Site 5: _____	 Pathology Solutions GI00001-6 Patient Name: _____ Site 6: _____	 Pathology Solutions GI00001-7 Patient Name: _____ Site 7: _____	 Pathology Solutions GI00001-8 Patient Name: _____ Site 8: _____