

WYOMING VALLEY PATHOLOGY

300 LAIRD STREET • SUITE A2
 WILKES-BARRE, PA 18702
 Phone: (570) 235-1372
 Fax: (570) 235-1780

Surgical Requisition

PATIENT LAST NAME										FIRST					MI			BIRTHDATE				SEX		
STREET ADDRESS																	PLEASE ATTACH COPY OF PATIENT'S INSURANCE CARD							
CITY										STATE					ZIP			PHONE #						
GUARANTOR'S NAME										STREET ADDRESS					CITY			STATE		ZIP		PHONE #		
BILL: <input type="checkbox"/> PATIENT <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> INSURANCE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAL																	MRN/SSN #							
INSURANCE COMPANY NAME							SUBSCRIBER NAME							MEMBER ID #										
GROUP #					INSURANCE ADDRESS																			
ICD-9/ICD-10 Codes (Required)																								
CC PHYSICIAN (Add fax)												REQUESTOR SIGNATURE												

SPECIMEN/CLINICAL INFORMATION		
Date Specimen Collected: _____	Time Specimen Collected: _____	Total # of Vials: _____
SPECIMEN SITE:	PATIENT HISTORY:	
1. _____	_____	
2. _____	_____	
3. _____	_____	
4. _____	_____	
5. _____	_____	
6. _____	_____	
7. _____	_____	
8. _____	_____	
9. _____	_____	
10. _____	_____	

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JOSEPH ANDREWS, M.D.
 RIVERVIEW AMBULATORY SURGICAL CENTER
 Phone: (570) 331-2040
 Fax: (570) 331-2043

Gastroenterology Requisition

PATIENT LAST NAME			FIRST			MI			BIRTHDATE			SEX					
STREET ADDRESS									PLEASE ATTACH COPY OF PATIENT'S INSURANCE CARD								
CITY			STATE			ZIP			PHONE #								
GUARANTOR'S NAME			STREET ADDRESS			CITY			STATE			ZIP			PHONE #		
BILL: <input type="checkbox"/> PATIENT <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> INSURANCE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID									MRN/SSN #								
INSURANCE COMPANY NAME						SUBSCRIBER NAME						MEMBER ID #					
GROUP #						INSURANCE ADDRESS											
ICD-9/ICD-10 Codes (Required)																	
CC PHYSICIAN (Add fax)									REQUESTOR SIGNATURE								

SPECIMEN/CLINICAL INFORMATION

NO. OF SPECIMENS: _____

PROCEDURE:

- Colonoscopy
- Sigmoidoscopy
- Upper Endoscopy

SPECIMEN SITE:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PREOPERATIVE DX:

- Anemia (Iron Deficiency)
- Change in Bowel Habits
- Colon Carcinoma Screen
- Diarrhea (Acute Chronic)
- Dysphagia
- Epigastric Pain
- Family History of Colon Cancer
- Gastroesophageal Reflux Dis.
- GI Bleeding
- Hematochezia
- Heme Positive Stools
- Hemorrhoids
- History of Barrett's Metaplasia
- History of Colon Polyps
- History of Gastric Ulcer
- History of Helicobacter Pylori
- IBD (UC Chron's)
- Malabsorption Symptoms
- Melena
- Other: _____

HISTORY/OTHER INFORMATION:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

POST OPERATIVE DX:

- Colon Mass R/O CA
- Colon Polyps
- Diverticulosis
- Duodenal Mass R/O CA
- Duodenal Ulcer
- Duodenitis
- Dysplasia-Mass R/O CA
- Esophageal Mass R/O CA
- Gastric Mass R/O CA
- Gastric Ulcer
- Gastritis
- Gastroesophageal Reflux
- Hemorrhoids
- Hiatal Hernia
- IBD R/O Dysplasia
- Prom. Ampulla of Vater
- Prom. Ileocecal Valve
- Rectal Mass R/O CA
- Rectal Polyps
- R/O Barrett's Metaplasia
- R/O Celiac Disease/Sprue
- R/O C. Diff/Antibiotic Assoc. Colitis
- R/O Dysplasia in Barrett's
- R/O Eosinophilic Gastroenteritis
- R/O Giardia
- R/O Helicobacter Pylori
- R/O IBD (UC Chron's)
- R/O Ileitis
- R/O Ischemic Colitis
- R/O Microscopic Colitis
- Solitary Rectal Ulcer Syndrome
- Normal
- Other: _____

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Urology Requisition

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CITY										STATE										ZIP										PHONE #																																							
GUARANTOR'S NAME										STREET ADDRESS										CITY										STATE										ZIP										PHONE #																			
BILL:										<input type="checkbox"/> PATIENT										<input type="checkbox"/> PHYSICIAN										<input type="checkbox"/> INSURANCE										<input type="checkbox"/> MEDICARE										<input type="checkbox"/> MEDICAID										MRN/SSN #									
INSURANCE COMPANY NAME										SUBSCRIBER NAME										MEMBER ID #																																																	
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BLADDER

(Check all that apply)

- V10.51 History of Bladder Cancer
 599.71 Gross Hematuria
 Other (with ICD-9/ICD-10): _____

PROSTATE

(Check all that apply)

- V10.46 History of Prostate Cancer
 790.93 Elevated PSA
 600.90 Hyperplasia of Prostate
 Other (with ICD-9/ICD-10): _____

CYTOLOGY/FISH

- Urine Cytology only
 UroVysion™ by FISH
 Urine Cytology with Reflex to UroVysion™ by FISH
 Bladder Biopsy

If Cytology is: Positive Atypical/Suspicious Negative

SPECIMEN COLLECTION:

- Bladder Wash Cath Urine Cystoscopy Ileal Conduit
 Ureteral Brushing Voided Urine
 Other: _____

PROSTATE

- COLLECTION METHOD:** TURBT Needle Core Biopsy TURP Cold Cup Biopsy Other: _____
Bx INDICATIONS: Elevated PSA Mass/Abnormal DRE Other: _____

BIOPSY SITE/SOURCE:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____