G

PROPATH
A Sonic Healthcare Anatomic Pathology Practice

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www.ProPath.com

REFERRED BY

PATIENT INFORMATION - PLEASE PRINT: PATIENT NAME (LAST) (FIRST) (M.I.)		
ADDRESS		APT#
CITY	STATE	ZIP
(AREA CODE) PHONE	BIRTH DATE	SEX
PATIENT S.S. #	PATIENT I.D.#	

BILL TO: ☐ **Account** ☐ **Patient (Self Pay)** ☐ **Medicare** ☐ **Medicaid** ☐ **Insurance** ***Please submit a copy of ID card (front and back)**

INSURANCE COMPANY NAME (attach card)	EMPLOYER NAME	
NAME OF INSURED	POLICY / MEMBER ID #	GROUP #

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

MAIL CLAIM TO

ADDRESS

CITY/STATE/ZIP

Referring Physician: ______ NPI: ______

DATE COLLECTED

Send Duplicate Report to: ______
Name: ______
Address: ______
City/State/Zip: ______

Medicare Patients Only

Must complete Advance Beneficiary Notice (ABN) on back of the first copy of this requisition.

PHYSICIAN ACKNOWLEDGEMENT (Required)

Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient. ***Medicare Patients: The Advance Beneficiary Notice, if required, must be completed, signed by the patient and attached.***

Physician's Signature: ______ **Date Ordered:** ______

DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

DIAGNOSIS CODE	DIAGNOSIS CODE	DIAGNOSIS CODE

GASTROINTESTINAL PATHOLOGY REQUISITION

ENDOSCOPIC CODES

Please write the applicable number(s) for each corresponding biopsy specimen in the next section below.
DO NOT CIRCLE CODE NUMBERS.

1. EROSION
2. COLITIS
3. ULCER
4. MASS
5. NODULE
6. CELIAC SPRUE
7. POLYP(S)
8. ESOPHAGITIS
9. GASTRITIS
10. STRICTURE
11. R/O MICROSCOPIC COLITIS
12. BARRETT'S
13. DUODENITIS
14. R/O DYSPLASIA
15. R/O H. PYLORI, IMMUNOSTAIN
16. R/O EOSINOPHILIC ESOPHAGITIS
17. GIARDIA IMMUNOSTAIN
18. OTHER: ______

BIOPSY DATA ESOPHAGUS
(One of the following boxes MUST be checked in order to perform tissue testing)

SPECIMEN	LOCATION (Check only one)					ENDOSCOPIC FINDINGS
# or Letter	PROXIMAL	MID	DISTAL	E.G. JUNC	CM / OTHER	(See Codes Left)
	☐	☐	☐	☐		
	☐	☐	☐	☐		
	☐	☐	☐	☐		
	☐	☐	☐	☐		

BIOPSY DATA STOMACH / DUODENUM
(One of the following boxes MUST be checked in order to perform tissue testing)

SPECIMEN	LOCATION (Check only one)						ENDOSCOPIC FINDINGS
# or Letter	FUNDUS	BODY	ANTRUM	PYLORUS	DUODENUM	OTHER	(See Codes Left)
	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐		
	☐	☐	☐	☐	☐		

BIOPSY DATA LARGE BOWEL / TERMINAL ILEUM
(One of the following boxes MUST be checked in order to perform tissue testing)

SPECIMEN	ANATOMIC SITE (Check only one)										LOCATION (Check only one)						ENDOSCOPIC FINDINGS
# OR LETTER	ILEUM	CECUM	ASCEND	HEP. FLEX	TRANS	SPLENIC FLEX	DESCEND	SIGMOID	RECTUM	ANUS	PROX	DISTAL	CM	ANASTOMOSIS	J POUCH	RANDOM	(See Codes Left)
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	

CLINICAL DATA
SYMPTOMS & SIGNS (Check all that apply)

- ☐ DYSPHAGIA
- ☐ HEARTBURN
- ☐ ANOREXIA
- ☐ OCCULT BLOOD
- ☐ NSAID USAGE
- ☐ REFLUX
- ☐ WEIGHT LOSS
- ☐ ABDOMINAL PAIN
- ☐ DYSPEPSIA
- ☐ DIARRHEA
- ☐ FAMILY HISTORY COLON CANCER
- ☐ BARRETT'S
- ☐ HNPCC
- ☐ PERSONAL HISTORY POLYPS
- ☐ CONSTIPATION
- ☐ VOMITING
- ☐ COLON POLYP
- ☐ NAUSEA
- ☐ NAUSEA & VOMITING
- ☐ ANEMIA
- ☐ BLEEDING
- ☐ PAIN
- ☐ PERSONAL HISTORY CANCER ______
- ☐ OTHER ______

NOTE: LABEL EACH SPECIMEN WITH PATIENT FIRST & LAST NAME

v10/22

Please include the diagnosis code(s) at the highest level of specificity as documented in the patient medical record for this requisition date of service.