HC

PROPATH
A Sonic Healthcare Anatomic Pathology Practice

1355 RIVER BEND DRIVE
DALLAS, TX 75247
P 214.638.2000
P 800.258.1253
F 214.237.1731
www.ProPath.com

REFERRED BY

Complete Shaded Box For Patient And Third Party Billing

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)**
(Check one) ☐ **Inpatient (Discharge Date _____)** ☐ **Outpatient**
PLEASE NOTE: Technical Component of services for Hospital-registered Medicare, Medicaid, and Tricare patients will be billed to the Hospital.

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

				AM PM

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

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

DIAGNOSIS CODE	DIAGNOSIS CODE	DIAGNOSIS CODE

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:** _____

HISTOLOGY & CYTOLOGY CENTER REQUISITION

Cytology

URINE CYTOLOGY AND FISH TESTING

☐ Voided Urine ☐ Catheterized Urine

☐ Bladder Washing

☐ Renal Wash R _____ L _____

☐ Ureteral Wash R _____ L _____

☐ Post-Cystoscopy Voided Urine

Volume: _____ mL

☐ Urine Cytology ☐ Urinary FISH panel

☐ Urine Cytology with REFLEX urinary FISH panel:

☐ If atypical or suspicious

☐ if atypical, suspicious, or malignant

☐ Urine Cytology and urinary FISH

☐ Other: _____

_____

OTHER CYTOLOGY

☐ Nipple Discharge: ☐ Right ☐ Left

☐ Fine Needle Aspiration

Source: _____

R _____ L _____

☐ Sputum ☐ Anal Cytology

Additional Info/Other: _____

_____

_____

_____

_____

_____

_____

Tissue Pathology

TISSUE SPECIMENS

SEPCIMEN SITE

A _____

B _____

C _____

D _____

E _____

F _____

V11/22

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.