B

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

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.#

(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

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

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:** _____

BREAST PATHOLOGY REQUISITION

PATIENT INFORMATION

☐ Asymptomatic
☐ History of Local Trauma
☐ Mass
  ☐ Stable Size
  ☐ Enlarging
☐ Palpable
☐ Skin Change
☐ Ill-Defined ☐ Well-Defined
☐ Painful / Tender
☐ Family History
  ☐ Premenopausal Breast Cancer _____
  ☐ Postmenopausal Breast Cancer _____
☐ Clincial Impression _____

CLINICAL HISTORY

Previous BX: ☐ Right ☐ Left ☐ FNA ☐ Core ☐ Excisional
☐ Benign Breast Disease
☐ Carcinoma (Site: _____ Date:_____/_____/_____)
☐ Chemotherapy ☐ Radiation

IMAGING

☐ Mammogram ☐ Ultrasound
☐ No Lesion Seen ☐ Mass ☐ Architectural Distortion
☐ Suspicious Calcifications ☐ Benign Calcification

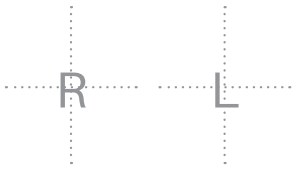
SPECIMEN INFORMATION

	BREAST	AXILLA				
A(1) A(1)	_____ Right/Left	_____ Right/Left	_____, O'clock	_____ CMFN	☐ Sono ☐ Stereo ☐ MRI	☐ FNA ☐ Smear
B(2) B(2)	_____ Right/Left	_____ Right/Left	_____, O'clock	_____ CMFN	☐ Sono ☐ Stereo ☐ MRI	☐ FNA ☐ Smear
C(3) C(3)	_____ Right/Left	_____ Right/Left	_____, O'clock	_____ CMFN	☐ Sono ☐ Stereo ☐ MRI	☐ FNA ☐ Smear

CLINICAL DIAGRAM & INFORMATION

(Mark Location of Biopsy)

RIGHT O'clock _____ CMFN _____



LEFT O'clock _____ CMFN _____

_____
_____
_____
_____

SURGICAL PROCEDURE

☐ Core Needle Biopsy ☐ True Cut
☐ Fine Needle Aspiration: # passes _____
☐ FNA of Cyst Fluid (Amount: _____ mL Color: _____)
☐ Stereotactic ☐ Ultrasound ☐ Other: _____
Nipple Discharge Smears #: _____ Spontaneous? ☐ Yes ☐ No
Needle Rinse Fluid: Type _____ Volume _____ mL

BREAST MARKERS STUDIES FIXATION *(ASCO/CAP REQUIREMENT)*

☐ 10% Neutral Buffered Formalin (NBF) ☐ Other: _____
Collection Time: _____ AM/PM Time Placed in Fixative: _____ AM/PM
Block(s): Fixation Duration: ☐ <6 hours ☐ 6-72 hours ☐ >72 hours ☐ Unknown

TEST(S)

☐ Comprehensive Assessment (Morphology w/ reflex to IHC + FISH w/ additional studies as necessary)
☐ ProPath Basic Profile (Includes IHC stains for ER, PgR, Ki-67, and HER2)
- If HER2 IHC is equivocal (score 2+), reflex FISH for HER2 gene amplification status is performed.
☐ HER2 by IHC, with reflex FISH for HER2 if equivocal (score 2+)
☐ HER2 by FISH for gene amplification status
☐ IHC for individual markers (circle): ER PgR Androgen Receptors HER2 Ki-67 p53
☐ P13K Mutation Analysis by PCR
☐ Other: _____

01/23

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.