S

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.#		

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: ______________

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

SURGERY CENTER REQUISITION

PREVIOUS BIOPSY NUMBER: ______________ PREVIOUS BIOPSY RESULTS: ______________ IMMUNOFLOURESCENCE (PART ________)

SPECIMEN NUMBER	SPECIMEN SOURCE/SITE	PRE/POST-OP DIAGNOSIS	MARGINS REQUESTED	COMMENTS	SPECIMEN TYPE*
A (1)			☐		☐ Bx ☐ P. Bx. ☐ Ex ☐ Sh. Ex.
B (2)			☐		☐ Bx ☐ P. Bx. ☐ Ex ☐ Sh. Ex.
C (3)			☐		☐ Bx ☐ P. Bx. ☐ Ex ☐ Sh. Ex.
D (4)			☐		☐ Bx ☐ P. Bx. ☐ Ex ☐ Sh. Ex.
E (5)			☐		☐ Bx ☐ P. Bx. ☐ Ex ☐ Sh. Ex.
F (6)			☐		☐ Bx ☐ P. Bx. ☐ Ex ☐ Sh. Ex.
G (7)			☐		☐ Bx ☐ P. Bx. ☐ Ex ☐ Sh. Ex.
H (8)			☐		☐ Bx ☐ P. Bx. ☐ Ex ☐ Sh. Ex.

FROZEN SECTION DIAGNOSES

A (1)	
B (2)	
C (3)	
D (4)	

☐ Frozen Section was Performed during this Procedure

Clinical History / Impression / Other Information: ______________

A Name ______________

C Name ______________

B Name ______________

D Name ______________

Bx — Biopsy Ex — Excision P.Bx. — Punch Biopsy Sh. Ex. — Shave Excision

NOTE: BE SURE TO LABEL THE SPECIMEN CONTAINER WITH PATIENT NAME AND SOURCE/SITE 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.