LMC PATHOLOGY SERVICES
An Aurora Diagnostics Partner

GASTROINTESTINAL PATHOLOGY REQUISITION

LABEL HERE

CLIENT INFORMATION

Send duplicate report to | Name: | Fax:

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	PATIENT ID NUMBER

ADDRESS

☐ MALE ☐ FEMALE

DATE OF BIRTH / /

CITY STATE ZIP

PHONE ( )

BILLING INFORMATION

PLEASE ATTACH A COPY OF THE PATIENT'S DRIVERS LICENSE - FRONT AND BACK - AND A COPY OF THE PATIENT'S INSURANCE CARD - FRONT AND BACK

Financial and release of information authorization: In consideration for services rendered, I/we hereby assign the benefits due me covering the services provided by Laboratory Medicine Consultants, including major medical benefits. I/we authorize the release of information necessary for insurance purposes. Furthermore, that in consideration of service rendered to the patient, I/we hereby obligate myself/ourselves to assume responsibility for full payment of account.

NAME OF INSURED (SUBSCRIBER) LAST FIRST MI

PATIENT IS: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY INSURANCE ☐ PPO ☐ HMO	ID NUMBER	GROUP NAME/NUMBER

INSURANCE ADDRESS CITY STATE/ZIP

SECONDARY INSURANCE/ADDRESS ☐ PPO ☐ HMO	ID NUMBER	GROUP NAME/NUMBER

INSURED PATIENT SIGNATURE FOR FINANCIAL AND RELEASE OF INFORMATION	DATE	PLEASE BILL (CHECK BOX) ☐ DOCTOR/CLIENT ☐ PATIENT ☐ INSURANCE

DIAGNOSIS (SPECIFY ICD 9)	1.	2.	3.	4.

SPECIMEN INFORMATION: COLLECTION DATE ____/____/____ COLLECTION TIME ____:____ AM PM

IMPORTANT MEDICARE PATIENTS: THE ADVANCE BENEFICIARY NOTICE, IF REQUIRED, MUST BE COMPLETED, SIGNED BY THE PATIENT, AND ATTACHED **IMPORTANT**

INDICATIONS/MEDICAL HISTORY

☐ Abdominal/Epigastric Pain
☐ Anemia
☐ Barrett's Surveillance
☐ Dyspepsia
☐ GERD (Reflux)
☐ H.pylori Follow-Up
☐ Heme-Positive Stool
☐ Malabsorbtion
☐ Nausea/Vomiting
☐ Peptic Ulcer Follow-Up
☐ PPI/H2 Blockers
☐ Weight Loss

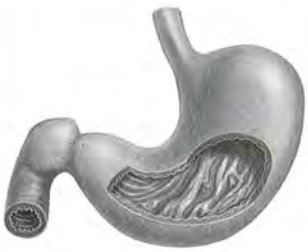
Colon Cancer Screening: ☐ Average ☐ High Risk High Risk Indication: ____

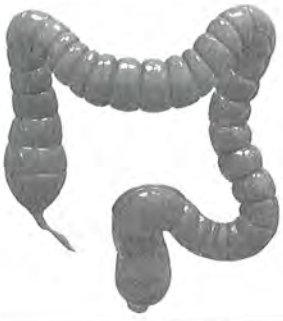
Surveillance for: ☐ Ulcerative Colitis ☐ Crohn's ☐ Polyp(s) ☐ Cancer (Type) ____

Symptoms: Diarrhea: ☐ Acute ☐ Chronic ☐ Watery ☐ Bloody
☐ Change in Bowel Habits/Constipation ☐ Heme-Positive Stool
☐ Rectal Bleeding ☐ Other:

SPECIAL REQUESTS

RULE OUT ☐ Barrett's Esophagus/Dysplasia ☐ Eosinophilic Esophagitis ☐ H.pylori ☐ Celiac Sprue ☐ Microscopic Colitis ☐ Ulcerative Colitis
☐ Crohn's ☐ Lymphoma ☐ Carcinoma ☐ Fungi ☐ Virus ☐ Amyloid ☐ Other: ____





Indicate Biopsy Site

Other Instructions

Findings

SPECIMEN SITE

A. ____	F. ____
B. ____	G. ____
C. ____	H. ____
D. ____	I. ____
E. ____	J. ____

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WHITE - LAB USE 1 YELLOW - LAB USE 2 PINK - CLIENT COPY