INOVA®
Laboratories
2832 JUNIPER STREET-FAIRFAX, VA 22031
703-645-6175

# BREAST PATHOLOGY REQUISITION

**PATIENT INFORMATION – all yellow highlighted fields are required information**

ICD: | ICD: | ICD:

| PATIENT LAST NAME | | | FIRST NAME | |
|---|---|---|---|---|
| SEX (M-Male F-Female) | DATE OF BIRTH (mm/dd/yyyy) | SOCIAL SECURITY # | PHONE | PHONE (Other) |
| ADDRESS | | CITY | STATE | ZIP |

| PRIMARY BILLING PARTY | SECONDARY BILLING PARTY |
|---|---|
| ATTACH INSURANCE CARDS | |
| INSURANCE CARDRIER | INSURANCE CARRIER |
| POLICY # | POLICY # |
| GROUP#/ENROLLMENT CODE | GROUP#/ENROLLMENT CODE |
| INSURANCE ADDRESS | INSURANCE ADDRESS |
| SUBSCRIBER | RELATIONSHIP TO PATIENT |

**ORDERING MD:** ______________________ (LAST) ______________________ (FIRST) ☐ **FAX TO** ______________

**OR**

**ORDERING MD:** ______________________ (PHONE) ☐ **CALL TO** ______________

**PHYSICIAN TO RECEIVE REPORT:** ______________________

**PHYSICIAN TO RECEIVE REPORT:** ______________________

**CLINICAL DATA (REQUIRED)**

______________________

______________________ ☐ **RULE OUT CALCIFICATIONS**

**HISTOLOGY**

**Collection Date** ___ /___ /___ **Time Collected** __________ **AM/PM (circle one)** **(Required for Breast Tissue)** **Time in Formalin** __________ **AM/PM (circle one)** **(Required for Breast Tissue)**

**SPECIMEN LOCATION** (Check all that apply) / **COLLECTION METHOD**

| Jar # | Left Breast | Right Breast | Nipple | Subareolar | Axilla | Other | Clock Position (Circle) | Marker | Mammotome | Stereotactic | Surgical / Excision | Ultrasound Guided | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ___ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | 1 2 3 4 5 6 7 8 9 10 11 12 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ___ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | 1 2 3 4 5 6 7 8 9 10 11 12 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
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| ___ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | 1 2 3 4 5 6 7 8 9 10 11 12 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**CYTOLOGY**

Collection Date ____/___/____ # of Jar(s) / Container(s) ___________

☐ FNA ______________________

MASS Size: _________ cm

Location: ______________________

Duration: ______________________

Consistency: ______________________

*Circle all that apply:*

Solid / Cystic

Solitary / Multiple

Circumscribed / Diffuse

Evacuated: ☐ Completely ☐ Incompletely

☐ Nipple Smear ______________________

Comments: ______________________

**PROGNOSTIC TESTING** (Reflex testing only performed on malignant specimens)

- ☐ Reflex to ER*, PR* and HER-2/neu*
- ☐ Reflex to ER* and PR*
- ☐ Reflex to HER-2/neu*
- ☐ Reflex to HER-2 by FISH if HER-2 byi IHC equals +2
- ☐ Reflex to HER-2 by FISH if HER-2 byi IHC equals +1
- ☐ Estrogen Receptor (ER)*
- ☐ Progesterone Receptor (PR)*
- ☐ HER-2 by IHC*
- ☐ DNA by Image Analysis
- ☐ KI67*
- ☐ p53 Tumor Suppressor Gene*

*Medicare provides limited coverage for CPT code 88342 (Immunohistochemistry). Please only order these tests when they are medically necessary or have the patient sign an ABN.

**Notice to Physicians:**
Diagnosis codes must be provided for each test ordered. Only tests you believe are appropriate for patient care should be ordered. Medicare will only pay for tests that are medically necessary for the diagnosis and treatment of the patient. Medicare does not generally cover routine screening tests.

220310000001 Jar # ___ Patient ___ DOB ___ Test / Site ___ Date ___

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## CLINICAL DATA (REQUIRED)

☐ RULE OUT CALCIFICATIONS

## HISTOLOGY

Collection Date ___ /___ /___　Time Collected ______AM/PM (circle one) (Required for Breast Tissue)　Time in Formalin ______AM/PM (circle one) (Required for Breast Tissue)

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| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | 1 2 3 4 5 6 7 8 9 10 11 12 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | 1 2 3 4 5 6 7 8 9 10 11 12 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | 1 2 3 4 5 6 7 8 9 10 11 12 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
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| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | 1 2 3 4 5 6 7 8 9 10 11 12 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## CYTOLOGY

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☐ FNA ______

MASS　Size: ______ cm　*Circle all that apply:*

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