GI Pathology From Form

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"Focusing on Anatomic Pathology"
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LAB USE ONLY

GI1001

CLIENT

Patient Last Name	First Name	MI	DOB MM/DD/YEAR	Age	Sex ☐M ☐F	Social Security # – –

Patient Home Address	Apt.#	City	State	Zip	Home Phone ( ) --	Alternative Phone ( ) --

Bill To: ☐ Client ☐ Patient ☐ Insurance ☐ Medicare (ABN) signed ☐ Medi-Cal (Attach POE) ☐ Work Comp ☐ HMO/IPA Authorization Number: _____

Patient is: ☐ Subscriber ☐ Spouse ☐ Dependent ☐ Other _____

Primary Ins. Name _____ ID# _____ Group # _____

Secondary Ins. Name _____ ID# _____ Group # _____

Employer's Name _____ City _____ Tel (____) _____ - _____

Please attach front and back copies of insurance card(s).

Info in This Box Will Appear on the Report:

Ordering Physician's Name:

NOTE: WHEN ORDERING TESTS FOR WHICH MEDICARE OR MEDI-CAL (MEDICAID) REIMBURSEMENT IS SOUGHT, PHYSICIANS SHOULD ONLY ORDER TESTS THAT ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS OR TREATMENT OF A PATIENT, RATHER THAN FOR SCREENING PURPOSES.

CLINICAL HISTORY / DATA

☐ Cancer (Type)_____	☐ History of Polyps/Cancer	☐ Anorexia	☐ Colitis Surveillance Colonoscopy	☐ R/O H. pylori
☐ Barrett's Esophagus	☐ Lower GI Bleeding	☐ Bleeding _____	☐ Rule Out Cancer	☐ R/O H. pylori
☐ Polyps	☐ Dysphagia	☐ Dyspepsia	☐ Rule Out Celiac Sprue	☐ R/O Barrett's Esophagus
☐ Idiopathic IBD	☐ Reflux	☐ Hem. Positive Stool	☐ Rule Out Dysplasia	☐ R/O Barrett's Esophagus
☐ Cancer Screening	☐ History of IBD	☐ Iron Deficient Anemia	☐ Rule Out H. Pylori	☐ R/O Fungi
☐ Ulcerated	☐ Malabsorption	☐ NSAID Usage	☐ Rule Out Idiopathic IBD	☐ R/O Candidiasis
☐ Nausea/Vomiting	☐ Diarrhea Bloody	☐ Pain	☐ Rule Out Infectious Etiology	☐ R/O Viral Inclusion
☐ Diverticular Disease	☐ Diarrhea Watery	☐ Weight Loss	☐ Rule Out (Other) _____	☐ R/O Celiac/Sprue
☐ Other _____	☐ Travel History _____	☐ Heart Burn	☐ Polyp/Neoplasm Surveillance	

ENDOSCOPIC FINDINGS

☐ Erosion	☐ Mass	☐ Polyp	☐ Erythema	☐ Nodularity	☐ Ulcerated	☐ Barrett's	☐ Salmon Patch
☐ Polyposis	☐ Stricture	☐ Granularity	☐ Normal	☐ Pseudomembrane	☐ Hiatal Hernia	☐ Irregular Z Line	☐ Hemorragic
☐ Inflated	☐ Mass Lesion	☐ Possible Polyp	☐ Obvious Polyp	☐ Possible Submucosal Lesion	☐ Atrophic	☐ Fissures	

SPECIMEN LOCATIONS

Specimen #1 _____

Specimen #2 _____

Specimen #3 _____

Specimen #4 _____

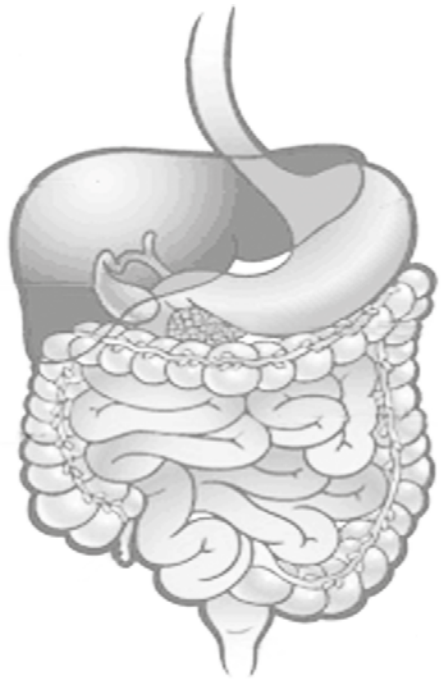
Specimen #5 _____

Specimen #6 _____

Specimen #7 _____

Specimen #8 _____

SPECIMEN INFORMATION



ADDITIONAL TEST REQUESTS / INFORMATION / INSTRUCTIONS

GI1001 (1)	GI1001 (2)	GI1001 (3)	GI1001 (4)	GI1001 (5)	GI1001 (6)	GI1001 (7)	GI1001 (8)

Physician's Signature: _____ **Date:** _____/_____/_____

Rev. 10-2010

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* Beneficiary's signature is required on reverse side.