CBM | PATHOLOGY

CYTOLOGY, BIOPSY, MICROSCOPY
18207A Flower Hill Way
Gaithersburg, MD 20879
Phone (301) 926 4707 Fax (301) 926 4708

REFERRING/ORDERING M.D.: **UPIN#:**	SIGNATURE OF ORDERING M.D. *(or designated person)*
ADDRESS:	ADDITIONAL M.D. NAME AND ADDRESS:

SURGICAL BIOPSY REQUISITION FORM

PATIENT LAST NAME: FIRST: MI:

SEX: M F

PATIENT SOCIAL SECURITY#:

DATE OF BIRTH: ___/___/____

PATIENT'S COMPLETE ADDRESS:

NAME OF INSURED/RESPONSIBLE PARTY(*last, first, MI*):
ADDRESS OF INSURED/RESPONSIBLE PARTY:

PATIENT/RESPONSIBLE PERSON SIGNATURE:

BILL TO: ___PATIENT ___INSURANCE *(fill information below or attach a copy of the patient's information sheet, **and** attach a copy of the insurance card(s), front and back)*

INSURED SOCIAL SECURITY # *(if not patient)*:

MEDICARE #: MEDICAID#

PRIMARY INSURANCE Relationship to insured: __SELF __SPOUSE __DEPENDENT

INSURANCE COMPANY NAME:______________________________________
MEMBER/INSURED ID#:____________________ GROUP #:____________________
HMO / PPO *(circle)*
INSURANCE ADDRESS:

SECOND INSURANCE Relationship to insured: __SELF __SPOUSE __DEPENDENT

INSURANCE COMPANY NAME:______________________________________
MEMBER/INSURED ID#:____________________ GROUP #:____________________
HMO / PPO *(circle)*
INSURANCE ADDRESS:

COLLECTION DATE:
____/____/_______

ICD-9 CODE(S):

SPECIMEN SOURCE :

A.______________________ **F.**______________________

B.______________________ **G.**______________________

C.______________________ **H.**______________________

D.______________________ **I.**______________________

E.______________________ **J.**______________________

CYTOLOGY/FNA ALSO SUBMITTED: ___

CLINICAL DATA:

PREVIOUS CASES: Date: __/__/___ Site:______________
Diagnosis:_________________

CURRENT MEDICAL HX:__________________________________

PREVIOUS MEDICAL HX:__________________________________

SPECIAL REQUESTS:____________________________________

PRELIMINARY DIAGNOSIS/SPECIAL STUDIES ORDERED: