



445260176300

2832 JUNIPER STREET • FAIRFAX, VA 22031

Specimen Pickup - Lab Results (703) 645-6175

STAT  BILL:  OFFICE  PAT. INSURANCE  PATIENT

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
<b>ATTACH INSURANCE CARDS</b>	
INSURANCE CARRIER	INSURANCE CARRIER
POLICY #	POLICY #
GROUP#/ENROLLMENT CODE	GROUP#/ENROLLMENT CODE
INSURANCE ADDRESS	INSURANCE ADDRESS
SUBSCRIBER	RELATIONSHIP TO PATIENT
ORDERING MD: _____ LAST FIRST	<input type="checkbox"/> FAX TO _____ OR
ORDERING MD: _____ PHONE	<input type="checkbox"/> CALL TO _____
PHYSICIAN TO RECEIVE REPORT: _____	
PHYSICIAN TO RECEIVE REPORT: _____	

HISTOPATHOLOGY				
Date Collected:	Time Collected:	Collected By:	Time in Formalin (Required for Breast)	# of Specimen Containers
<input type="checkbox"/> <b>BIOPSY--List Sites/Sources below---(SURQ)</b> Should Correspond To Container				
A _____				<input type="checkbox"/> <b>BONE MARROW</b> <input type="checkbox"/> With Slides <input type="checkbox"/> With No Slides <input type="checkbox"/> Iron Stain Only
B _____				<input type="checkbox"/> <b>BONE MARROW</b> Leukemia Immunoflow Cytometry
C _____				<input type="checkbox"/> <b>BONE MARROW CHROMOSOMES</b>
D _____				<input type="checkbox"/> <b>GROSS ONLY</b>
E _____				<b>Notice to Physicians:</b> 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.
F _____				

PRE OP DIAGNOSIS: \_\_\_\_\_

POST OP DIAGNOSIS: \_\_\_\_\_

CLINICAL HISTORY: \_\_\_\_\_

445260176300 Pt. Full Name: _____ Collect: _____ / _____ : _____ Site/Source: _____	DOB: ____/____/____	445260176300 Pt. Full Name: _____ Collect: _____ / _____ : _____ Site/Source: _____	DOB: ____/____/____	445260176300 Pt. Full Name: _____ Collect: _____ / _____ : _____ Site/Source: _____	DOB: ____/____/____
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\_\_\_\_ Vial  
 \_\_\_\_ Slide  
 \_\_\_\_ L-LAV  
 \_\_\_\_ Micro  
**FOR OFFICIAL USE ONLY**

INTEGRATED LABEL

SOURCE 4 - TO REORDER CALL (804) 794-6923

172281

IRL-C (Rev. 09/17)



445260176300



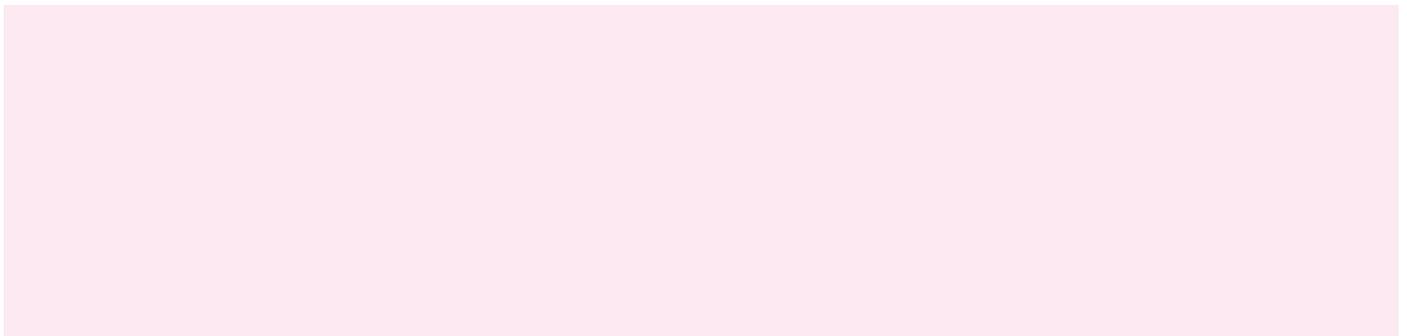
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Pt. Full Name: _____ Collect: _____ / _____ : _____ Site/Source: _____ DOB: ____/____/____	Pt. Full Name: _____ Collect: _____ / _____ : _____ Site/Source: _____ DOB: ____/____/____	Pt. Full Name: _____ Collect: _____ / _____ : _____ Site/Source: _____ DOB: ____/____/____

<input type="checkbox"/> Vial <input type="checkbox"/> Slide <input type="checkbox"/> L-LAV <input type="checkbox"/> Micro <b>FOR OFFICIAL USE ONLY</b>
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