ALLIANCE LABORATORIES OF WESTCHESTER
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GI 1082

GI Pathology Requisition

True Partners in Laboratory Diagnostics

PATIENT INFORMATION

Last Name	First Name		
Address		Apt #	
City	State	Zip Code	
Phone	Sex	Age	DOB
Social Security #	MR/Chart #:		

COLLECTION INFORMATION

Collection Date: ____/____/____ Time: ____:____ AM PM

ACCOUNT INFORMATION

BILLING INFORMATION

Name of Insured		
Company Name		
Street Address		
City	State	Zip Code
Policy #	Group #	
Medicare/ Medicaid #	Referral #	

INDICATIONS / PERTINENT MEDICAL HISTORY (Check all that apply)

- ☐ Abdominal Pain (Type): _____
- ☐ Anemia
- ☐ Anorexia
- ☐ Bleeding _____
- ☐ Change in Bowel Habits
- ☐ Diarrhea (Bloody/Watery)
- ☐ Dyspepsia
- ☐ Dysphagia
- ☐ Heartburn
- ☐ Hem. Positive Stool
- ☐ Nausea/Vomiting
- ☐ NSAID Usage
- ☐ Screening
- ☐ Weight Loss
- ☐ Hx. of Barrett's Esophagus
- ☐ Hx. of Cancer (Type) _____
- ☐ Hx. of Crohn's
- ☐ Hx. of H. Pylori
- ☐ Hx. of IBD
- ☐ Hx. of Lymphoma
- ☐ Hx. of Polyps
- ☐ Hx. of Reflux
- ☐ Hx. of UC
- ☐ Family Hx. of Cancer (Type) _____
- ☐ Other: _____

ICD-10: _____

SPECIAL INDICATIONS

- ☐ Polyp/Neoplasm Surveillance
- ☐ R/O Barrett's Esophagus
- ☐ R/O Cancer
- ☐ R/O Candida
- ☐ R/O Colitis
- ☐ R/O Microscopic Colitis
- ☐ R/O Ulcerative Colitis
- ☐ R/O Crohn's
- ☐ R/O Dysplasia
- ☐ R/O Fungi
- ☐ R/O H. Pylori
- ☐ R/O IBD
- ☐ R/O Parasites
- ☐ R/O Sprue
- ☐ R/O Viral Inclusions
- ☐ R/O Other_____

ANATOMIC SITE

Specimen # and Site	TYPE: Bx. (formalin) / Polyp (formalin) / Brushing (CytoLyt)	UPPER GI: ESOPHAGUS: Upper / Proximal / Distal / EG Junction (NOS)	UPPER GI: STOMACH: Cardia / Fundus / Body / Antrum/Pylorus (NOS)	UPPER GI: DUODENUM: Duodenum (Bulb) / Duodenum (2nd) / Duodenum (3rd) (NOS)	LOWER GI: ILEUM: Ileum / Terminal Ileum / Ileocecal Valve	LOWER GI: COLON: Cecum / Ascending / Hepatic Flexure / Transverse / Splenic Flexure / Descending / Sigmoid / Rectum / Anus (NOS)	LOWER GI: COLON: Proximal / Mid / Distal	ENDOSCOPIC FINDINGS CODES (Use numbers from the list below)
A. ____ cm	☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐	☐☐☐	_____
B. ____ cm	☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐	☐☐☐	_____
C. ____ cm	☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐	☐☐☐	_____
D. ____ cm	☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐	☐☐☐	_____
E. ____ cm	☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐	☐☐☐	_____
F. ____ cm	☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐	☐☐☐	_____
G. ____ cm	☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐	☐☐☐	_____
H. ____ cm	☐☐☐	☐☐☐☐☐	☐☐☐☐☐	☐☐☐☐	☐☐☐	☐☐☐☐☐☐☐☐☐	☐☐☐	_____

POST OPERATIVE Dx. (Endoscopic Findings)

1. Barrett's Mucosa
2. Diverticula
3. Erosion
4. Erythema
5. Granularity
6. Hiatal Hernia
7. H. Pylori
8. Inflammation
9. Mass
10. Nodularity
11. Normal
12. Polyp
13. Polyposis
14. Pseudomembrane
15. Random bx.
16. Stricture
17. Ulcer
18. Other: _____

ICD-10: _____

Pt. Name: GI 1082	Pt. Name: GI 1082	Pt. Name: GI 1082	Pt. Name: GI 1082
Site:	Site:	Site:	Site:
Jar#: _____ ALLIANCE LABORATORIES	Jar#: _____ ALLIANCE LABORATORIES	Jar#: _____ ALLIANCE LABORATORIES	Jar#: _____ ALLIANCE LABORATORIES
Pt. Name: GI 1082	Pt. Name: GI 1082	Pt. Name: GI 1082	Pt. Name: GI 1082
Site:	Site:	Site:	Site:
Jar#: _____ ALLIANCE LABORATORIES	Jar#: _____ ALLIANCE LABORATORIES	Jar#: _____ ALLIANCE LABORATORIES	Jar#: _____ ALLIANCE LABORATORIES

Non-Medicare Patients: I hereby authorize Alliance Laboratories of Westchester to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Alliance Laboratories of Westchester. I understand that I am responsible for any amount not paid by insurance for reasons including, but not limited to, non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient/Responsible Party Signature: _____