1 Westchester Plaza Elmsford, NY 10523
P: 914-307-1678 - F: 914-345-3064

AS1085

Ambulatory Surgery 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 #	

RULE OUT / SUSPECTED DIAGNOSIS

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____

____

ICD-10 Codes: ______________________________

CLINICAL INFORMATION

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____

MARK SPECIMEN SITE

HISTOLOGY

SPECIMEN(S)

JAR	TYPE / SITE
A.	
B.	
C.	
D.	
E.	

HISTOLOGY

SPECIMEN(S)

JAR	TYPE / SITE
F.	
G.	
H.	
I.	
J.	

MYCOLOGY EVALUATION

For optimal results, collect both formalin, and unfixed specimens. If limited tissue is available, send specimen unfixed.
Priority of testing Histology, Culture then KOH

SPECIMENS

JAR	Type / Site	Histology w/PAS Stain	Fungal Culture	KOH
A.		☐	☐	☐
B.		☐	☐	☐
C.		☐	☐	☐

CYTOLOGY

JAR	TYPE / SITE	
A.	FNA Site: ____________	Size: ____cm.
B.	FNA Site: ____________	Size: ____cm.

WOUND CULTURE

☐ Wound Culture and Sensitivity (Swab)

JAR	TYPE / SITE
A.	

Pt. Name: AS 1085 Site: Jar#: ALLIANCE	Pt. Name: AS1085 Site: Jar#: ALLIANCE	Pt. Name: AS 1085 Site: Jar#: ALLIANCE	Pt. Name: AS1085 Site: Jar#: ALLIANCE
Pt. Name: AS 1085 Site: Jar#: ALLIANCE	Pt. Name: AS1085 Site: Jar#: ALLIANCE	Pt. Name: AS 1085 Site: Jar#: ALLIANCE	Pt. Name: AS1085 Site: Jar#: ALLIANCE

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: ______________________________