Breast Pathology

Alliance Laboratories
7200 W. Camino Real, Suite 330,
Boca Raton, FL 33433
Tel: 561-453-1234
Fax: 561-453-1238

PATIENT INFORMATION — BP1000

Last Name	First Name		
Address			Apt #
City	State	Zip Code	
Phone	Sex	Age	DOB
Social Security #	Medical Record #		

COLLECTION INFORMATION

Date: ____/____/____

Removal Time: ____:____ am/pm

Fixation Time: ____:____ am/pm

LAB USE ONLY

Case #: _____

Date Received: ___/___/____

Time Received: _____

BILLING INFORMATION

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

ACCOUNT INFORMATION

DIAGNOSTIC INFORMATION (ICD-9 Code)

	Right Breast	Left Breast	Unspecified
Breast Cyst	N60.01	N60.02	N60.09
Malignant Neoplasm-Nipple & Areola	C50.011	C50.012	C50.019
Malignant Neoplasm-Central Portion	C50.111	C50.112	C50.119
Malignant Neoplasm-Upper-Inner Quad	C50.211	C50.212	C50.219
Malignant Neoplasm-Lower-Inner Quad	C50.311	C50.312	C50.319
Malignant Neoplasm-Upper-Outer Quad	C50.411	C50.412	C50.419
Malignant Neoplasm-Lower-Outer Quad	C50.511	C50.512	C50.519
Malignant Neoplasm of Axillary Tail	C50.611	C50.612	C50.619

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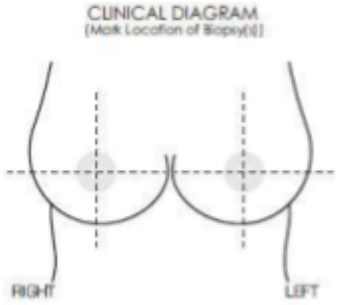
PERTINENT CLINICAL INFORMATION



SURGICAL PROCEDURE

- ☐ Sono - Guided Vacuum- Assisted Biopsy, _____ g Cores
- ☐ Stereo - Guided Vacuum - Assisted Biopsy, _____ g Cores
- ☐ MRI - Guided Vacuum - Assisted Biopsy, _____ g Cores
- ☐ Core Needle Biopsy
- ☐ Lumpectomy/Excisional Biopsy
- ☐ Fine Needle Aspiration (FNA)/Cyst Aspiration

☐ Other_____

HISTOPATHOLOGY (Formalin Fixative)		HISTOPATHOLOGY (Formalin Fixative)
Time of Specimen removal _____:_____ am/pm Time Specimen placed in Formalin _____:_____ am/pm 1. _____Breast, _____, _____CMFN Side O'clock #	□ Sono □Stereo □ MRI □ FNA	Diagnoses of **DCIS** will be tested for: ER & PR by immunohistochemistry (IHC) Diagnoses of **INVASIVE CARCINOMA** will be tested for: ER, PR, Ki-67, p53 & HER-2/neu by Immunohistochemistry (IHC) Additional testing at physician request: □ **HER-2 by FISH** □ **BRAC** □ **Other**
Time of Specimen removal _____:_____ am/pm Time Specimen placed in Formalin _____:_____ am/pm 2. _____Breast, _____, _____CMFN Side O'clock #	□ Sono □Stereo □ MRI □ FNA	
Time of Specimen removal _____:_____ am/pm Time Specimen placed in Formalin _____:_____ am/pm 3. _____Breast, _____, _____CMFN Side O'clock #	□ Sono □Stereo □ MRI □ FNA	

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Non-Medicare Patients: I hereby authorize University Pathology to furnish my designated insurance carrier with the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Alliance Laboratories. 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: _____