ALLIANCE LABORATORIES
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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
☐ Hem. Positive Stool
☐ Nausea/Vomiting
☐ NSAID Usage
☐ Reflux
☐ 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
☐ Hx. of Eosinophilic Gastroenteropathy
☐ Family Hx. of Cancer (Type) ____________
☐ Other: ________________________________

ICD-10: ___________________

SPECIAL INDICATIONS (Check all that apply)

☐ 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 Drug-Induced Injury _________
☐ R/O Parasites
☐ R/O Sprue
☐ R/O Viral Inclusions
☐ R/O Other_______________

ANATOMIC SITE

☐ **Check Box if Endoscopy Report Attached**

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)	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) (Check all that apply)

☐ Barrett's Mucosa
☐ Diverticula
☐ Erosion
☐ Erythema
☐ Granularity
☐ Hiatal Hernia
☐ H. Pylori
☐ Inflammation
☐ Ischemic Bleeding
☐ Mass
☐ Nodularity
☐ Normal
☐ Parasites
☐ Polyp
☐ Polyposis
☐ Pseudomembrane
☐ Random bx.
☐ Stricture
☐ Ulcer

Other: ______________________ **ICD-10:** ________________________

Pt. Name: ____________ Site: ____________ Jar#: ________ ALLIANCE	Pt. Name: ____________ Site: ____________ Jar#: ________ ALLIANCE	Pt. Name: ____________ Site: ____________ Jar#: ________ ALLIANCE	Pt. Name: ____________ Site: ____________ Jar#: ________ ALLIANCE
Pt. Name: ____________ Site: ____________ Jar#: ________ ALLIANCE	Pt. Name: ____________ Site: ____________ Jar#: ________ ALLIANCE	Pt. Name: ____________ Site: ____________ Jar#: ________ ALLIANCE	Pt. Name: ____________ Site: ____________ Jar#: ________ ALLIANCE

Non-Medicare Patients: I hereby authorize Alliance Laboratories 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. 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: ____