ANATOMIC PATHOLOGY TEST REQUEST

IRVINE PATHOLOGY MEDICAL GROUP, INC.

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PATIENT INFORMATION	**CLIENT/PHYSICIAN INFORMATION**
NAME (last, first) SEX M [ ] F[ ]	**Office:**
DATE OF BIRTH PATIENT SS	**Tel:** **Fax:**
PATIENT ADDRESS PATIENT TEL. #	**Dr.**
DIAGNOSIS: Please insert narrative diagnosis or ICD-10 codes.	

Ordering Physician Name (please print): **FAX NUMBER:**

Report Copies to: **PHONE NUMBER:**

PATIENT AUTHORIZATION

Irvine Pathology Medical Group's services are not included with the main procedure billed by your physician or facility. I will be financially responsible for tests billed by Irvine Pathology Medical Group as indicated for diagnosis.

Patient signature: ________________________ Date: ____________

BILLING INFORMATION

FOR PATIENT OR THIRD PARTY BILLING COMPLETE INFORMATION BELOW. IF FORM IS NOT COMPLETED CLIENT MAY BE BILLED. ATTACH COPY OF FRONT AND BACK OF PATIENT'S PRIMARY, SECONDARY INSURANCE CARDS AND MAIN PROCEDURE REFERRAL.

Bill to (check one) [ ] Patient [ ] Insurance [ ] HMO [ ] Client [ ] Medicare [ ]Medi-cal Auth. #: ______________	Insurance or HMO Name:____________ Address:____________ ____________ ____________	Group No:____________ Policy No:____________

SPECIMEN INFORMATION (REQUIRED)

Date collected:________ Time collected:________ Collector's name: ____________________

CLINICAL HISTORY (REQUIRED)

BIOPSY/CYTOLOGY

LIST SITE(S) TO CORRESPOND TO SPECIMEN CONTAINER(S)

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

White: IPMG Pink: Client/Physician

(Rev. 1/19)