avero DIAGNOSTICS

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BREAST PATHOLOGY REQUISITION

Specimen Collection Date:_____Time: _____

PATIENT INFORMATION

Patient Name (Last, First, MI)

SSN	DOB	Sex M / F

Address

City	State	ZIP

Patient Insurance Information - Please provide copy of insurance card(s)

Primary Insurance ☐Medicare ☐Ins. ☐Patient ☐Client Bill

Company

Policy / ID Number

Group Number

Secondary Insurance ☐Medicare ☐Ins. ☐Patient ☐Client Bill

Company

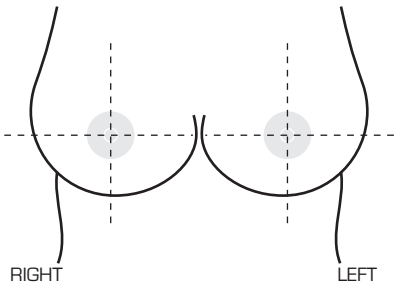
Policy / ID Number

Group Number

PHYSICIAN INFORMATION

PERTINENT CLINICAL INFORMATION

CLINICAL DIAGRAM
(Mark Location of Biopsy(s))



ACR Category:

DIAGNOSTIC INFORMATION (ICD-9)

✓	Check All that Apply.		
	611.72 Breast Mass		
	793.81 Microcalcifications		
	OTHER		

SURGICAL PROCEDURE

- ☐ Sono - Guided Vacuum- Assisted Biopsy, _____g Cores
- ☐ Stereo - Guided Vacuum - Assisted Biopsy, _____g Cores
- ☐ MRI - Guided Vaccum - Assisted Biopsy, _____g Cores
- ☐ Core Needle Biopsy
- ☐ Lumpectomy/Excisional Biopsy
- ☐ Fine Needle Aspiration (FNA)/Cyst Aspiration
- ☐ HALO™ Breast Pap Test
- ☐ Other_____

TEST OPTIONS

*Diagnoses of invasive carcinoma will be tested for ER,PR,Ki-67, p53 & HER-2/neu by immunohistochemistry(IHC)
*Diagnoses of DCIS will be tested for ER & PR.
*Additional testing at physician request:

- ☐ PathVysion (HER-2 FISH) Only
- ☐ TOP2A FISH
- ☐ PathVysion Plus TOP2A FISH
- ☐ Other_____

SPECIMEN INFORMATION (Anatomic Origin of Specimen)

1. _____Breast, _____ , _____CMFN	☐ Sono ☐ Stereo ☐ MRI ☐ FNA
2. _____Breast, _____ , _____CMFN	☐ Sono ☐ Stereo ☐ MRI ☐ FNA
3. _____Breast, _____ , _____CMFN	☐ Sono ☐ Stereo ☐ MRI ☐ FNA

SPECIMEN LABELS

123456789

The labels found below are for the purpose of identifying the specimens with this requisition. Please affix to the side of each specimen vial you are submitting.

123456789	1.	Breast, ,	CMFN	☐ Sono ☐ Stereo ☐ MRI ☐ FNA
123456789	2.	Breast, ,	CMFN	☐ Sono ☐ Stereo ☐ MRI ☐ FNA
123456789	3.	Breast, ,	CMFN	☐ Sono ☐ Stereo ☐ MRI ☐ FNA

ALL MEDICARE PATIENTS MUST COMPLETE THE FOLLOWING: Medicare will only pay for services determined to be "reasonable and necessary" under section 1662(a) of the Medicare law. If Medicare determines that a particular service is not reasonable and or necessary under Medicare program standards, Medicare will deny payment for that service.

Patient Signature:_____ Date:_____