



REQUISITION FORM

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Yorba Linda, CA 92886

PATIENT INFORMATION		REQUESTING PHYSICIAN INFORMATION	
LAST NAME	FIRST NAME	LAST NAME	FIRST NAME
GENDER M F	DATE OF BIRTH	UPIN NUMBER	NPI NUMBER
HOME ADDRESS		CLINIC ADDRESS	
HOME PHONE	WORK PHONE	OFFICE PHONE	OFFICE FAX
INSURANCE INFORMATION		DATE OF PROCEDURE	

CLINICAL INFORMATION	PHYSICIAN ACKNOWLEDGEMENT AND CERTIFICATION
HISTORY	<p>The undersigned physician acknowledges that: 1) The test ordered is medically necessary; 2) If test is ordered for the purposes of screening, the likelihood of denial of payments has been explained to the patient who has signed Advanced Beneficiary Notice and agreed to be personally and financially responsible for payment of denied test.</p> <p>ORDERING MD SIGNATURE</p>
DIAGNOSIS	

CYTOLOGY SPECIMENS		
FINE NEEDLE ASPIRATION (FNA) <input type="checkbox"/> SPECIFY SITE	SLIDE CONSULTATION <input type="checkbox"/> SPECIFY SITE (PLEASE INCLUDE ORIGINAL PATHOLOGY REPORT)	OTHERS <input type="checkbox"/> SPECIFY SERVICE REQUESTED

HISTOLOGY SPECIMENS		
ANATOMIC SITE	NAME OF PROCEDURE	PREVIOUS ABNORMAL HISTOLOGY