REQUISITION FORM

Telephone: 951-808-8863 **Fax: 951-808-0550** **www.pathcarefna.com**

1810 Fullerton Avenue, Suite 102
Corona, CA 92881

41667 Ivy Street, Suite G
Murrieta, CA 92562

17451 Bastanchury Road, Suite 104C
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	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.
DIAGNOSIS	ORDERING MD SIGNATURE

CYTOLOGY SPECIMENS		
FINE NEEDLE ASPIRATION (FNA)	**SLIDE CONSULTATION**	**OTHERS**
❑ SPECIFY SITE	❑ SPECIFY SITE (PLEASE INCLUDE ORIGINAL PATHOLOGY REPORT)	❑ SPECIFY SERVICE REQUESTED

HISTOLOGY SPECIMENS		
ANATOMIC SITE	NAME OF PROCEDURE	PREVIOUS ABNORMAL HISTOLOGY