HRPLABS
HATO REY PATHOLOGY ASSOCIATES, INC

BREAST SURGICAL PATHOLOGY DIVISION

Client # _____

Space Reserved for Laboratory use
Date Received:

Specimen # _____

EXAMINATION REQUEST FOR BREAST SPECIMEN

DATE OF COLLECTION: _____ TIME: _____ am/pm SLIDES QTY: _____ CONTAINERS QTY: _____

PATIENT'S INFORMATION

Patient's Name: _____ Record Number #: _____

Gender: _____ DOB: _____ Age: _____ Home Phone # _____ Cel. phone # _____

Postal Adress: _____ Email: _____

Medical Insurance: _____

☐ Check if patient wants to receive a bill for any deduction by mail
*pathologists may order additional testing based on medical necesity

Contract # _____ Group # _____

2nd Insurance: _____ Contract: _____ Group: _____

Notification to the Patient: All Samples sent to HRPLabs will be processed and diagnosed, and its outcome will be sent directly to the physician. If any deductible or copay applies or if you don't have medical insurance, you will receive an invoice for the payment. Toda muestra a HRPLabs será procesada y diagnosticada y el resultado será enviado a su médico. En caso de que haya algún deducible o copago, o de usted no estar cubierto por un seguro médico, recibirá factura y será responsable del pago de la misma.

PATIENT'S SIGNATURE: _____

CLINICAL HISTORY

ICD - 10	ICD - 10	ICD - 10	ICD - 10	ICD - 10
NOTES:				

SURGICAL SPECIMEN WORKSHEET

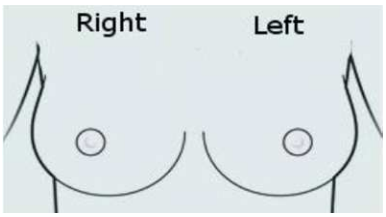
SPECIMEN PART: _____ **PREVIOUS DIAGNOSIS:** _____ **ER/PR/HER:** ☐ Yes ☐ No

PROCEDURE: ☐ Lumpectomy **without** wire-guided localization ☐ Lumpectomy **with** wire-guided localization ☐ Lumpectomy with seed localization
☐ Mastectomy (specify): _____ ☐ Other: _____

SIDE: ☐ Left ☐ Right **QUADRANT LOCALIZATION:** _____

MASS / LESSION SIZE: _____ CM **NEO-ADJUVANT THERAPY:** ☐ **POST - Tx SIZE:** _____ CM

ADDITIONAL INFORMATION:



N/A ☐ NEEDLE BIOPSY WORKSHEET

SPECIMEN PART: _____

SIDE: ☐ Left ☐ Right **QUADRANT LOCALIZATION:** _____

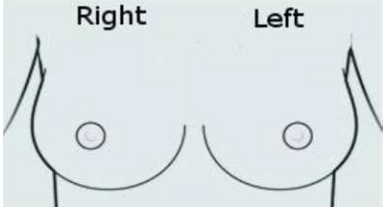
MASS / LESSION SIZE: _____ CM **CALCIFICATIONS:** ☐ Yes ☐ No

TECHNIQUE: ☐ Core, simple ☐ Core, mammotome ☐ FNA
☐ Vacuum Assisted ☐ Cyst Aspiration ☐ Nipple Discharge

NEEDLE GUIDANCE: ☐ Freehand ☐ Ultrasound ☐ Stereotactic ☐ Other: _____

NUMBER OF CORES: _____ (1 - 10, > 10) **X-ray cores:** ☐ Yes ☐ No **If yes; calcifications present:** ☐ Yes ☐ No

ADDITIONAL INFORMATION:



When ordering tests, proiders should only order tests that are medically necessary for the diagnosis or treatment of a patient, generally not forscreening. Only a few screening tests are covered by most government and third party payors for certain conditions at specific intervals. When ordering tests that are subject to ABN guidelines, refer to the policies published by your Medicare Administrative Contractor (MAC), or CMS. If testing does not come under Medicare guidelines for payment a signed beneficiary notice must be included in advance.

Physician's Signature: _____ NPI: _____ Date: _____

+Red fieldsand patient information must be completed to avoid delay in processing or sample rejection*