NovinoPath
www.novinopath.com

REQUISITION FORM
Pathology

NovinoPath Diagnostics
2619 Francis Lewis Blvd, Flushing, NY 11358
TEL: (718) 663-2118 FAX: (888) 377-1244

PART A: Patient Information - *Required*

Patient Name:______________________________

Date of Birth______________ Gender M____F____

Address:______________________________

City____________ State_____ Zip Code_________

Social Security:______________ EMR#___________

Specimen collection date:______________________

PART B: Provider Information - *Required*

Provider:______________________________

Address:______________________________

City____________ State_____ Zip Code_________

Phone:______________ Fax:______________

NPI#______________ Signature______________

Send Duplicate Report to: Name______________ Address/Fax______________________________

PART C: Indications/Clinical History: ______________________________

____

ICD-10 Code (*Required*): 1)____________ 2)____________ 3)____________ 4)____________

PART D: Insurance Billing Information: *Send Bill to:* Patient:____ Insurance:____

Name of Primary Insurance CO ____________________ Insured ID ______________ Group # __________

Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other ☐

Insured's Name ____________________________ Insured Date of Birth ______/______/________

Please Attach: 1) A copy of the front/back of patient's insurance card(s) or 2) Printout patient demographics and insurance information from your EHR

PART E: Biopsy Specimen Information: # of Container:__________

A:__________________________ **D:**__________________________ NOTE:

B:__________________________ **E:**__________________________

C:__________________________ **F:**__________________________

PART F: Cytology Specimen Information: # of Container:__________ # of slides:____________

1: Urine__________ Void:_______ Instrument:______ (*Please submit in sterile urine container or Cytolyte*)

2: Thyroid_________ Site A:______________ Site B:______________ Site C:______________

(*Please prep 1-2 airdried slide and make additional passes to put in Cytolyte*)

3: Breast:_________ Site A:______________ Site B:______________ Cystic:______ Solid:______

(*Please put all aspiration material in Cytolyte*)

4: Other:_________ Site:____________ (*Please prep 1-2 airdried slide and make additional passes to put in Cytolyte*)

FOR LAB USE ONLY:

Receiving Date:__________ Time:__________ Accession#____________________ Note:______________