

160 Allen Street, Rutland, VT 05701 | www.RRMC.org | 802.747.1771

NAME (LAST, FIRST, MI)		DOB	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NO.
ORDERING PROVIDER (PRINT NAME)		COPY TO		
ORDERING PROVIDER SIGNATURE			DATE/TIME	

NOTICE TO PROVIDER: FOR MEDICARE PATIENTS, YOU SHOULD ONLY ORDER THOSE TESTS YOU BELIEVE ARE MEDICALLY NECESSARY FOR THE DIAGNOSIS AND TREATMENT OF YOUR PATIENT. MEDICARE MAY DENY PAYMENT FOR A TEST YOU BELIEVE IS APPROPRIATE, SUCH AS SCREENING TEST, BUT WHICH DOES NOT MEET THE MEDICARE DEFINITION OF MEDICAL NECESSITY.

PLEASE FILL OUT BILLING INFORMATION BELOW OR ATTACH SEPARATE SHEET  NO INSURANCE (FILL OUT INFORMATION BELOW)

**BILLING INFORMATION**

RESPONSIBLE PARTY NAME		PHONE NO.
ADDRESS (STREET, STATE, ZIP CODE)		
MEDICARE NO.	MEDICAID NO.	STATE
INSURANCE COMPANY NAME	CERT. NO.	GROUP NO.
SUBSCRIBER NAME		RELATIONSHIP
EMPLOYER NAME		
EMPLOYER ADDRESS		

**SPECIMEN COLLECTION**

COLLECTION DATE	COLLECTION TIME	SPECIMEN RECEIVED DATE	LAB ACCESSION NO.
CLINICAL DIAGNOSIS/PERTINENT HISTORY	DIAGNOSIS CODE	<b>If you wish to decline reflex indicate here:</b> <input type="checkbox"/> Do not perform HER2 Assay HER2 testing is performed on core biopsies unless specifically requested.	

**SURGICAL PATHOLOGY TESTING (Tissue Samples)**

List each specimen source separately:


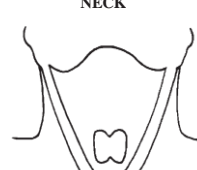
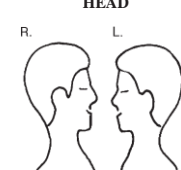
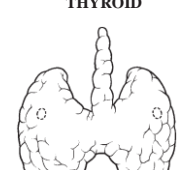
1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**NON-GYN CYTOLOGY TESTING (Cells/Fluid)**

<input type="checkbox"/> Anal Pap	<b>Specimen Site:</b> <input type="checkbox"/> Brushing <input type="checkbox"/> Washing <input type="checkbox"/> Skin Scraping (Tzanck Prep) <input type="checkbox"/> Other:
<input type="checkbox"/> CSF	
<input type="checkbox"/> Nipple Discharge <span style="margin-left: 20px;"><input type="checkbox"/> L <input type="checkbox"/> R</span>	
<input type="checkbox"/> Peritoneal Fluid/Ascites	
<input type="checkbox"/> Peritoneal Wash	
<input type="checkbox"/> Pleural Fluid <span style="margin-left: 20px;"><input type="checkbox"/> L <input type="checkbox"/> R</span>	
<input type="checkbox"/> Sputum, Expectorated	
<input type="checkbox"/> Sputum, Induced	
<input type="checkbox"/> Urine, Catheterized	
<input type="checkbox"/> Urine, Voided	
<input type="checkbox"/> Ureteral Washing <span style="margin-left: 20px;"><input type="checkbox"/> L <input type="checkbox"/> R</span>	
<input type="checkbox"/> Ureteral Brushing <span style="margin-left: 20px;"><input type="checkbox"/> L <input type="checkbox"/> R</span>	

SEE BACK OF THIS FORM FOR ANATOMIC PATHOLOGY REFLEX TESTING CRITERIA

**FINE NEEDLE ASPIRATE (FNA)**

	FNA Palpation	<b>BREAST</b>	<b>NECK</b>	<b>HEAD</b>	<b>THYROID</b>
	FNA Image Guided	 Distance from Nipple _____ Lump size _____	 Lump size _____	 Lump size _____	 Nodule size _____
Site of aspiration					
AIR DRIED SLIDES _____					
FIXED SLIDES _____					
NEEDLE RINSE _____					
OTHER _____					

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Patient Label

**BILLING NOTE**

We will submit a claim for hospital-related charges to your insurance, if appropriate, and send you a bill for any amount not covered by your insurance. Please Note: Some test procedures may be reviewed by a physician who is not employed by Rutland Regional. In these instances, you may receive a separate bill from that physician for their interpretation time. If you have questions about your bill, call 802.747.1751 or toll free 1.866.460.8277.

**PROCEDURE FOR COLLECTING AND SUBMITTING SPECIMENS TO SURGICAL PATHOLOGY & CYTOLOGY**

**Regular Working Hours - 7:00 am to 5:00 pm Monday through Friday:** The specimen should be sent immediately to Lab Central Accessioning.

**After 5:00 pm Monday through Friday, or on Weekends & Holidays:** The specimen should be sent immediately to Lab Central Accessioning.

**Lymph Nodes:** Handling depends on the tests that need to be performed.

- A. If there is a suspicion for Lymphoma (r/o lymphoma) and or cultures, transport tissue in a sterile container (such as a sterile Petri dish or urine cup). Sample should be moistened with normal saline and sent immediately to surgical pathology labeled “process for Lymphoma” and/or “please culture”.
- B. For other immediate evaluations (such as for intraoperative evaluation for metastatic disease), nodes need not be sterile, but should be sent immediately to the lab labeled “frozen section/touch prep”. Please include the intraoperative consultation form.
- C. If the node does not need immediate evaluation, it should be handled as other routine surgical pathology specimens. If here are any questions regarding the test to be performed call the Lab at 802.747.1786.

**Muscle & Nerve Biopsies** require that Histology be notified 24 hours before the specimen is obtained. Muscle biopsies are only performed during Regular Working Hours. Please call the Histology Laboratory at 802.747.1791. Muscle biopsies are placed on saline-soaked gauze (3 clamped specimens) and sent immediately in a labeled, closed container on ice to Surgical Pathology.

**Reflex Tests:** The following is a list of Surgical Pathology specimens subject that reflex in our laboratory.

**ANATOMIC PATHOLOGY SPECIMENS SUBJECT TO REFLEX**

See Lab Services Directory for more specific information. **If you wish to decline reflex testing, please indicate on front of requisition.**

Initial Specimen	Reflex Criteria	Reflex Test	Add'l CPT Billed
Breast excision for carcinoma	All invasive adenocarcinomas	1. ER/PR 2. HER 2 Neu IHC	3x 88360 3x 88360.26
Breast excision for carcinoma	HER 2 Neu with an indeterminate result (2+)	FISH	2x 88271 88274 88365
Breast biopsy	1st incidence of DCIS	ER/PR receptor testing	2x 88360 2x 88360.26