Pathologists
William J. Colburn, M.D.
Bryan T. Lin, M.D., Ph.D.
Igor Kozlov, M.D.

INTERSCOPE
PATHOLOGY

REQUEST FOR
TISSUE EXAMINATION • CONSULTATION / REVIEW SLIDE
SLIDE PREPARATION • NON CERVICAL / VAGINAL / CYTOLOGIC EXAMINATION

Date Collected___/______/____ Time Collected _______ AM / PM ☐ MALE ☐ FEMALE

STATE AND FEDERAL REGULATIONS REQUIRE YOU TO PROVIDE THE FOLLOWING PATIENT INFORMATION AND TO PRINT THE PATIENT'S NAME ON THE SPECIMEN OR THE SLIDE. FAILURE TO DO SO MAY REQUIRE US TO RETURN THE SPECIMEN.

PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION:

Last Name:	First Name:	M.I.	LAST FOUR OF SS#:	DOB: (mm/dd/yyyy)

Street Address:	City:	State:	Zip:	Phone:

INSURANCE INFORMATION (Attach copy of card or fill in below:)

BILL TO ☐ PATIENT ☐ MEDICARE ☐ MEDI-CAL ☐ INSURANCE: ☐ Blue Cross • ☐ Blue Shield • ☐ Aetna • ☐ Other________________

Guarantor if other than patient:	DOB: (mm/dd/yyyy)	Street Address:	City:	State:	Zip:

Subscriber/Medicare/Medi-Cal #:	Group ID:

Insurance Carrier Street Address:	City:	State:	Zip:

IF MEDICARE, PLEASE ATTACH ABN
I authorize release of medical records necessary to process this claim. I authorize payment of medical benefits to Interscope Pathology. I understand I am financially responsible for all charges incurred whether or not they are paid by Medicare or other insurance.

SIGNATURE:	Date:

NOTICE TO CUSTOMERS
Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 - www.mbc.ca.gov

☐ TISSUE EXAMINATION (LIST SOURCE ON RIGHT)
☐ CONSULTATION/SLIDE REVIEW
☐ NON GYN CYTOLOGIC EXAMINATION (CHECK SOURCE BELOW):
☐ URINE: ☐ CATH ☐ VOID
☐ BLADDER WASH ☐ FISH
☐ BREAST: ☐ LEFT ☐ RIGHT ☐ FNA ☐ CORE
☐ THYROID: ☐ LEFT ☐ RIGHT ☐ FNA ☐ CORE
☐ NEEDLE BIOPSY OTHER:______________________
☐ SPUTUM
☐ ANAL PAP ☐ HIGH RISK HPV ☐ REFLEX 16, 18/45 (HPV positive only)

CLINICAL IMPRESSION/ESSENTIAL HISTORY:

____
____
____

DIAGNOSIS:

____
____
____

SPECIMEN SOURCE (other than Prostate):

1. ____________________ 6. ____________________
2. ____________________ 7. ____________________
3. ____________________ 8. ____________________
4. ____________________ 9. ____________________
5. ____________________ 10. ____________________

PROSTATE (please number to match vials):

Left Base________________ Right Base________________
Left Mid ________________ Right Mid ________________
Left Apex ________________ Right Apex________________
Left Lat. Base________________ Right Lat. Base ____________
Left. Lat. Mid ________________ Right Lat. Mid. ____________
Left Lat. Apex________________ Right Lat. Apex ____________

21114 Vanowen Street, Canoga Park, CA 91303
Tel: (818) 992-7848 Fax: (818) 992-7943

Blue: Interscope White: Client