Neuropathology Requisition

UT Southwestern Medical Center

Neuropathology Laboratory
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Dallas, Texas 75390-9073
CLIA #45D-0659587
CAP#9041475

Office: 214-648-2148
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ACCOUNT INFORMATION

Client Name/Account Number:

Client Address:

City/State/Zip:

Client Phone: | Client FAX:

REQUIRED ORDER INFORMATION

BILL TO: ☐ Facility / Client ☐ Patient / 3rd party **– Billing information must be provided**

Patient Name: (Last, First, Middle)

Mother's Name: (if infant)

Date of Birth: | Sex: | Patient ID / MR#:

Hospital Inpatient Y / N | Collection Date: | Collection Time: : AM PM

Physician Requesting Biopsy: (Last, First, Middle) | NPI:

Phone: | Pager: | FAX:

Surgeon Requesting Biopsy: (Last, First, Middle) | NPI:

Phone: | Pager: | FAX:

Clinical Indication for Tests Ordered:

TESTS REQUESTED

- ☐ Muscle biopsy with enzyme histochemistry
- ☐ Nerve biopsy, complete
- ☐ Review outside slides
- ☐ Other: _____

3rd PARTY BILLING INFORMATION:

ICD-10 Code(s)

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) on reverse side. ☐ Signed ABN included

ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle) | Date of Birth:

Patient's relationship: ☐ Self ☐ Spouse ☐ Dependent ☐ Other | Responsible Party Address: (street, city, State, zip)

Sex: | Phone:

Employer's Name: | Employer's Phone:

Insurance Co. Name: | Insurance Co. Phone:

Insurance Co. Address:

Policy #: | Group #:

☐ Medicare ☐ HMO ☐ Other ☐ Medicaid ☐ PPO | Member ID#:

Referral Authorization/Precertification #:

Name: | Date/Time:

CLINICAL INFORMATION

Institution:

Laboratory Contact:

Surgical Pathology Number:

Primary Physician (if different from above)

Address:

Phone: | Fax:

Patient Ethnicity/Race | Age:

Brief history of illness (please attach additional sheets as needed)

ADDITIONAL INFORMATION (muscle/nerve biopsies)

Biopsy site(s): _____

Prior muscle/nerve biopsy? ☐ Yes ☐ No If so, when, where?: _____

CK: _____ Other relevant laboratory data: _____

EMG findings: _____ NCV findings: _____

Preliminary frozen section diagnosis requested? ☐ Yes ☐ No If yes, indicate reason: _____

Clinician to notify: _____ Phone: _____

Date/Time Received: _____

Condition of specimen: _____

Frozen (Dry Ice)_____ Wet Ice_____ Room temperature_____ Other_____ Initials: