

# Neuropathology Requisition

ACCOUNT INFORMATION	

## Neuropathology Laboratory

5323 Harry Hines Blvd., H2.130  
Dallas, Texas 75390-9073  
CLIA #45D-0659587  
CAP #2723201

Office: 214-648-2148

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www.veripathlabs.com

### REQUIRED ORDER INFORMATION

<b>BILL TO:</b>		<input type="checkbox"/> Facility / Client <input type="checkbox"/> 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
<b>Physician Requesting Biopsy:</b>		NPI:	
Phone:	Pager:	FAX:	
<b>Surgeon Requesting Biopsy:</b>		NPI:	
Phone:	Pager:	FAX:	

### 3rd PARTY BILLING INFORMATION:

<b>ICD-9 Code(s)</b>	
<b>Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) on reverse side.</b> <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	Responsible Party Address: (street, city, State, zip)
Sex:	Phone:
Employer's Name:	Employer's Phone:

**Clinical Indication for Tests Ordered:**

Insurance Co. Name: \_\_\_\_\_ Insurance Co. Phone: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

### TESTS REQUESTED

Muscle biopsy with enzyme histochemistry  
 Nerve biopsy, complete  
 Review outside slides  
 Other: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Medicare  HMO  Other  
 Medicaid  PPO

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: \_\_\_\_\_

**FOR VERIPATH USE ONLY: VERIPATH ACCESSION #** \_\_\_\_\_ **Date/Time Received:** \_\_\_\_\_

Condition of specimen: \_\_\_\_\_

Frozen (Dry Ice) \_\_\_\_\_ Wet Ice \_\_\_\_\_ Room temperature \_\_\_\_\_ Other \_\_\_\_\_ Initials: \_\_\_\_\_