BREAST REQUISITION

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PLEASE PRINT - COMPLETE ALL AREAS **OR** ATTACH DEMOGRAPHIC SHEET **AND** FILL IN THE SHADED SECTIONS.

Patient Name: (Last, First)			Medicare #:
Date of Birth: _____/_____/_____	Sex: ☐ M ☐ F	Telephone:	Medicaid #:
Social Security #:	MR #:		Commercial Ins. Name:
Address: (Mailing)			Commercial Ins. Policy: / Group #:
(City, State, Zip)			Commercial Ins. Address (Street):
Requesting Clinician Name (Last, First):			(City, State, Zip)
Physician Office/Clinic/Hospital Name:			Copy to Clinician Name (Last, First, and office location):
Collection Date & Time: _____/_____/_____ _____:_____	Requisition completed by:		☐ Correlation with previous or concurrent case: _____

PRIORITY:
☐ Routine
☐ Next business day rapid (will call office)
☐ Next day rapid (will call provider on weekends and holidays) Provider contact # required _____

LOCATION OF COLLECTION:
☐ Day Surgery ☐ OR
☐ Emergency Room ☐ Physician office patient
☐ Inpatient Floor ☐ Radiology/Ultrasound

CLINICAL INFORMATION (REQUIRED FOR ALL TESTS-include patient diagnosis & history)

Post-Op Diagnosis:

Procedure / Type of Specimen:

#	Source of Specimen (specify left or right)	Time of Excision (removal from patient)	Time of Placement into 10% Buffered Formalin
1			
2			
3			
4			
5			

Orientation:

Lumpectomy Specimen Orientation Information:
- Accurately ink margins as follows: Superior-Red, Inferior-Blue, Anterior-Green, Posterior-Black, Medial-Yellow, and Lateral- Orange.
- Incise into tumor/mass or area of interest after the specimen is appropriately oriented and covered with ink.

Mastectomy Specimen Information:
- Cover deep margin with black ink then incise into clinically apparent tumor mass