ACCU | REFERENCE MEDICAL LAB SM
1901 EAST LINDEN AVE.
SUITE 4, LINDEN, NJ 07036
T: (908) 474-1004
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Specimen #
For Lab Use ONLY

# GASTROINTESTINAL PATHOLOGY

**REQUESTING PHYSICIAN**

**PATIENT INFORMATION**

Last Name: _____ First Name _____

Middle Name: _____ Date of Birth (Required) __/__/__ Gender (Req.) ☐F ☐M

Date Specimen Collected (Req.) __/__/__ Phone: (___) _____

Street Address _____ Apt. # _____ SSN: ___-___-____

City: _____ State: _____ Zip: _____ Pt. ID _____

**BILLING INFORMATION**

PLEASE ATTACH A COPY OF THE INSURANCE CARD (FRONT AND BACK), OR FILL IN THE NECESSARY INFORMATION BELOW, THANK YOU

☐ **Check here if self-pay** (If checked, please, attach the acknowledgment form) ☐ **Secondary insurance exists.** If checked, please include a photocopy of both carriers and clearly indicate primary and secondary.

Insurance Carrier: _____ Address _____ City: _____ State: _____ Zip: _____

Name of Insured (if different from patient): _____ Insurance ID: _____ Group # _____

BOB of Insured __/__/__ Gender ☐F ☐M Relationship to subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

**CLINICAL INFORMATION**

**Family Hx of:** ☐ Cancer (type) _____ ☐ Syndrome (type) _____

**Personal Hx of:** ☐ Barrett's Esophagus ☐ IBD ☐ H. pylori ☐ Polyps (type) _____ ☐ Cancer (type) _____

**ICD 9 Code(s)** _____

☐ Anorexia/Early satiety
☐ Bleeding
  ☐ Melena
  ☐ Bright Red Blood P.R.
☐ Diarrhea (bloody)
☐ Diarrhea (watery)

☐ Dyspepsia
☐ Heartburn
☐ Malabsorption
☐ Nausea/Vomiting
☐ NSAID use
☐ Reflux

☐ Screening
☐ Weight Loss
☐ Pain _____
☐ Other: _____

**CLINICAL INFORMATION**

☐ Colitis Surveillance
☐ Polyp/Neoplasm Surveillance
☐ R/O Barrett's Esophagus
☐ R/O HSV ☐ R/O CMV
☐ R/O H. pylori ☐ R/O Fungi
☐ R/O Other

**BIOPSY DATA**

| | SPECIMEN | TYPE (check one only) | COLON / ILEUM (check one only) | | STOMACH/ DUODENUM | ESOPHAGUS | Use codes from list on right |
|---|---|---|---|---|---|---|---|
| A | ____ CM | ☐ Biopsy<br>☐ Polypectomy<br>☐ Other ____ | ☐ Ileum<br>☐ Cecum<br>☐ Ascending<br>☐ Transverse | ☐ Descending<br>☐ Sigmoid<br>☐ Rectum | ☐ Cardia<br>☐ Fundus/Body<br>☐ Antrum<br>☐ Duodenum | ☐ Proximal<br>☐ Middle<br>☐ Distal<br>☐ GE Junction | ____ |
| B | ____ CM | ☐ Biopsy<br>☐ Polypectomy<br>☐ Other ____ | ☐ Ileum<br>☐ Cecum<br>☐ Ascending<br>☐ Transverse | ☐ Descending<br>☐ Sigmoid<br>☐ Rectum | ☐ Cardia<br>☐ Fundus/Body<br>☐ Antrum<br>☐ Duodenum | ☐ Proximal<br>☐ Middle<br>☐ Distal<br>☐ GE Junction | ____ |
| C | ____ CM | ☐ Biopsy<br>☐ Polypectomy<br>☐ Other ____ | ☐ Ileum<br>☐ Cecum<br>☐ Ascending<br>☐ Transverse | ☐ Descending<br>☐ Sigmoid<br>☐ Rectum | ☐ Cardia<br>☐ Fundus/Body<br>☐ Antrum<br>☐ Duodenum | ☐ Proximal<br>☐ Middle<br>☐ Distal<br>☐ GE Junction | ____ |
| D | ____ CM | ☐ Biopsy<br>☐ Polypectomy<br>☐ Other ____ | ☐ Ileum<br>☐ Cecum<br>☐ Ascending<br>☐ Transverse | ☐ Descending<br>☐ Sigmoid<br>☐ Rectum | ☐ Cardia<br>☐ Fundus/Body<br>☐ Antrum<br>☐ Duodenum | ☐ Proximal<br>☐ Middle<br>☐ Distal<br>☐ GE Junction | ____ |
| E | ____ CM | ☐ Biopsy<br>☐ Polypectomy<br>☐ Other ____ | ☐ Ileum<br>☐ Cecum<br>☐ Ascending<br>☐ Transverse | ☐ Descending<br>☐ Sigmoid<br>☐ Rectum | ☐ Cardia<br>☐ Fundus/Body<br>☐ Antrum<br>☐ Duodenum | ☐ Proximal<br>☐ Middle<br>☐ Distal<br>☐ GE Junction | ____ |

**ENDOSCOPIC CODES**

Please write the applicable number(s) for each corresponding specimen in the section to the left.

1. NORMAL
2. Erosion
3. Erythema
4. Granularity
5. Mass
6. Nodularity
7. Hiatal Hernia
8. H. pylori
9. Polyp
10. Polyposis
11. Pseudomebrane
12. Stricture
13. Ulcer
14. Barrett's Mucosa
15. Other: _____

**Physician's Siganture:** _____ **Date** _____

NOTE: SPECIMEN CONTAINERS MUST INCLUDE PATIENT NAME AND BIOPSY SITE