ONCOLOGY / HEMATOPATHOLOGY REQUISITION FORM

17150 Newhope Street, Suite 117
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714-433-1330
FAX 714-755-2984

CALIFORNIA LAW REQUIRES THE FOLLOWING INFORMATION BE COMPLETED AND ALL SPECIMENS BE LABELED WITH PATIENTS NAME

PATIENT INFORMATION

	DATE OF BIRTH	SEX M F	SOCIAL SECURITY NUMBER
NAME LAST FIRST M.I.	PHONE ( )	CHART #	
STREET APT. NO.	CITY	STATE	ZIP

BILLING INFORMATION

☐ BILL INSURANCE (COPY CARD AND ATTACH) ☐ ADOC
☐ BILL CLIENT
☐ BILL PATIENT DIRECTLY
☐ BILL PATIENT'S VISA, M/C ____________
Exp. Date ______ Authorized Signature ____________

☐ EDINGER MEDICAL GROUP
☐ BILL MEDI-CAL (COPY CARD AND ATTACH)
☐ **BILL MEDICARE (COPY CARD AND ATTACH)**

ICD-9 CODE: ____________

SPECIMAN SITE ____________

SPECIMEN(S) ☐ CORE ☐ CLOT

DATE COLLECTED ____________ TIME COLLECTED ____________ ☐ AM ☐ PM

CLINICAL HISTORY ____________

CLINICAL DIAGNOSIS ____________ R/O ____________

Please include the following:

☐ CBC RESULTS ☐ ASPIRATE SMEAR ☐ PERIPHERAL SMEAR

TESTING REQUESTED:

☐ FLOW CYTOMETRY: GREEN TOP TUBE OR PURPLE TOP TUBE

☐ CYOGENETICS: GREEN TOP TUBE

☐ Other: ____________

FOR LABORATORY USE