



Breast Pathology

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<https://www.lincolnreference.com/>

PATIENT INFORMATION																																							
ACCT:	Last Name		First Name	MI																																			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		D.O.B. / /																																				
	Address (Street)			Apt # Floor Room#																																			
	City		State	Zip	Telephone #																																		
Dr. Signature _____	Responsible Party/Subscriber		Social Security #	Client Chart/Pt. ID#																																			
Billing Information* <input type="checkbox"/> Bill Patient <input type="checkbox"/> Bill Client <input type="checkbox"/> Bill Medicare <input type="checkbox"/> Bill Medicaid <input type="checkbox"/> Bill Insurance <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER																																							
Insurance Company Name		Telephone #		ICD 10 DIAGNOSIS CODE(S) FOR TESTS ORDERED (REQUIRED)																																			
Subscriber Member #	Location	Group #	DIAGNOSIS/SIGNS SYMPTOM IN ICD-10 FORMAT (Highest Specificity)																																				
Insurance Address		Physician's Provider																																					
City		State			Zip																																		
MEDIWARE ADVANCE BENEFICIARY NOTICE (ABN)																																							
I have read the ABN on the reverse. If Medicare denies payment, I agree to pay for the identified test(s).																																							
		Patient's Signature _____ Date _____		24-HOUR URINE VOLUME IN ML																																			
				FASTING <input type="checkbox"/> YES <input type="checkbox"/> NO																																			
STAT																																							
DIAGNOSTIC INFORMATION (ICD-10 Code)		PERTINENT CLINICAL INFORMATION																																					
<table border="0" style="width:100%;"> <tr> <td style="width: 25%;">DX. Site</td> <td style="width: 25%;">Right Breast</td> <td style="width: 25%;">Left Breast</td> <td style="width: 25%;">Unspecified</td> </tr> <tr> <td>Breast Cyst</td> <td>N60-01</td> <td>N60-02</td> <td>N60-019</td> </tr> <tr> <td>Malignant Neoplasm-Nipple & Areola</td> <td>C50.011</td> <td>C50.012</td> <td>C50.019</td> </tr> <tr> <td>Malignant Neoplasm-Central Portion</td> <td>C50.111</td> <td>C50.112</td> <td>C50.119</td> </tr> <tr> <td>Malignant Neoplasm-Upper-Inner Quad</td> <td>C50.211</td> <td>C50.212</td> <td>C50.219</td> </tr> <tr> <td>Malignant Neoplasm-Lower-Inner Quad</td> <td>C50.311</td> <td>C50.312</td> <td>C50.319</td> </tr> <tr> <td>Malignant Neoplasm-Upper-Outer Quad</td> <td>C50.411</td> <td>C50.412</td> <td>C50.419</td> </tr> <tr> <td>Malignant Neoplasm-Lower-Outer Quad</td> <td>C50.511</td> <td>C50.512</td> <td>C50.519</td> </tr> <tr> <td>Malignant Neoplasm of Axillary Tail</td> <td>C50.611</td> <td>C50.612</td> <td>C50.619</td> </tr> </table>	DX. Site	Right Breast	Left Breast	Unspecified	Breast Cyst	N60-01	N60-02	N60-019	Malignant Neoplasm-Nipple & Areola	C50.011	C50.012	C50.019	Malignant Neoplasm-Central Portion	C50.111	C50.112	C50.119	Malignant Neoplasm-Upper-Inner Quad	C50.211	C50.212	C50.219	Malignant Neoplasm-Lower-Inner Quad	C50.311	C50.312	C50.319	Malignant Neoplasm-Upper-Outer Quad	C50.411	C50.412	C50.419	Malignant Neoplasm-Lower-Outer Quad	C50.511	C50.512	C50.519	Malignant Neoplasm of Axillary Tail	C50.611	C50.612	C50.619	<div style="text-align: center;"> <p style="font-size: x-small;">CLINICAL DIAGRAM [Mark Location of Biopsy(s)]</p> </div>		
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SURGICAL PROCEDURE																																							
<input type="checkbox"/> Sono - Guided Vacuum - Assisted Biopsy, _____ g Cores <input type="checkbox"/> Stereo - Guided Vacuum - Assisted Biopsy, _____ g Cores <input type="checkbox"/> MRI - Guided Vacuum - Assisted Biopsy, _____ g Cores <input type="checkbox"/> Core Needle Biopsy <input type="checkbox"/> Lumpectomy/Excisional Biopsy <input type="checkbox"/> Fine Needle Aspiration (FNA)/Cyst Aspiration																																							
HISTOPATHOLOGY (Formalin Fixative)		HISTOPATHOLOGY (Formalin Fixative)																																					
Time of Specimen removal _____:_____ am/pm Time Specimen placed in Formalin _____:_____ am/pm 1. _____ Breast _____, _____ CMFN Side _____ O'clock # _____	<input type="checkbox"/> Sono <input type="checkbox"/> Stero <input type="checkbox"/> MRI <input type="checkbox"/> FNA	Diagnoses of DCIS will be tested for: ER & PR by immunohistochemistry (IHC) Diagnoses of INVASIVE CARCINOMA will be tested for: ER, PR, Ki-67 & HER-2/neu by Immunohistochemistry (IHC) Additional testing at physician request <input type="checkbox"/> HER-2 by FISH <input type="checkbox"/> Other																																					
Time of Specimen removal _____:_____ am/pm Time Specimen placed in Formalin _____:_____ am/pm 2. _____ Breast _____, _____ CMFN Side _____ O'clock # _____	<input type="checkbox"/> Sono <input type="checkbox"/> Stero <input type="checkbox"/> MRI <input type="checkbox"/> FNA																																						
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Non-Medicare Patients: I hereby authorize Lincoln Reference Laboratory to furnish my designated insurance carrier with the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Lincoln Reference Laboratory. I understand that I am responsible for any amount not paid by insurance for reasons including, but not limited to, non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient/Responsible Party Signature: _____

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*FPO - Affixed Label Position
