INOVA
Laboratories

445260176300

2832 JUNIPER STREET • FAIRFAX, VA 22031

Specimen Pickup - Lab Results (703) 645-6175

STAT ☐ **BILL:** ☐ OFFICE ☐ PAT. INSURANCE ☐ PATIENT

PATIENT LAST NAME		FIRST NAME		
SEX (M-Male F-Female)	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY #	PHONE	PHONE (Other)
ADDRESS		CITY	STATE	ZIP

PRIMARY BILLING PARTY	SECONDARY BILLING PARTY
ATTACH INSURANCE CARDS	
INSURANCE CARRIER	INSURANCE CARRIER
POLICY #	POLICY #
GROUP#/ENROLLMENT CODE	GROUP#/ENROLLMENT CODE
INSURANCE ADDRESS	INSURANCE ADDRESS

SUBSCRIBER RELATIONSHIP TO PATIENT

ORDERING MD: _____ (LAST / FIRST) ❑ **FAX TO** _____

OR

ORDERING MD: _____ (PHONE) ❑ **CALL TO** _____

PHYSICIAN TO RECEIVE REPORT: _____

PHYSICIAN TO RECEIVE REPORT: _____

HISTOPATHOLOGY

Date Collected:	Time Collected:	Collected By:	Time in Formalin (Required for Breast)	# of Specimen Containers

❑ **BIOPSY – List Sites/Sources below --- (SURQ)** Should Correspond To Container

A _____

B _____

C _____

D _____

E _____

F _____

❑ **BONE MARROW**
- ❑ With Slides
- ❑ With No Slides
- ❑ Iron Stain Only

❑ BONE MARROW
Leukemia Immunoflow Cytometry

❑ BONE MARROW CHROMOSOMES

❑ GROSS ONLY

Notice to Physicians:
Diagnosis codes must be provided for each test ordered. Only tests you believe are appropriate for patient care should be ordered. Medicare will only pay for tests that are medically necessary for the diagnosis and treatment of the patient. Medicare does not generally cover routine screening tests.

PRE OP DIAGNOSIS: _____

POST OP DIAGNOSIS: _____

CLINICAL HISTORY: _____

445260176300 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____	445260176300 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____	445260176300 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____
445260176300 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____	445260176300 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____	445260176300 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____

INTEGRATED LABEL

_____ Vial
_____ Slide
_____ L-LAV
_____ Micro

FOR OFFICIAL USE ONLY

___/___/___

SOURCE 4 - TO REORDER CALL (804) 794-5923

172281

IRL-C (Rev. 09/17)

Form# IRL-C; rev. 09/2017

445260176300

445260176300

445260176300

445260176300

INOVA Laboratories

2832 JUNIPER STREET • FAIRFAX, VA 22031

Specimen Pickup - Lab Results (703) 645-6175

445260176300

STAT ☐ **BILL:** ☐ OFFICE ☐ PAT. INSURANCE ☐ PATIENT

PATIENT LAST NAME				FIRST NAME		
SEX (M-Male F-Female)	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY #	PHONE	PHONE (Other)		
ADDRESS				CITY	STATE	ZIP

PRIMARY BILLING PARTY	SECONDARY BILLING PARTY
ATTACH INSURANCE CARDS	
INSURANCE CARRIER	INSURANCE CARRIER
POLICY #	POLICY #
GROUP#/ENROLLMENT CODE	GROUP#/ENROLLMENT CODE
INSURANCE ADDRESS	INSURANCE ADDRESS
SUBSCRIBER	RELATIONSHIP TO PATIENT

ORDERING MD: ______________________ ❏ **FAX TO** ______________

LAST FIRST

OR

ORDERING MD: ______________________ ❏ **CALL TO** ______________

PHONE

PHYSICIAN TO RECEIVE REPORT: ______________________

PHYSICIAN TO RECEIVE REPORT: ______________________

HISTOPATHOLOGY

Date Collected:	Time Collected:	Collected By:	Time in Formalin (Required for Breast)	# of Specimen Containers

❏ **BIOPSY – List Sites/Sources below---(SURQ)** Should Correspond To Container

A ______________________

B ______________________

C ______________________

D ______________________

E ______________________

F ______________________

❏ **BONE MARROW**
- ❏ With Slides
- ❏ With No Slides
- ❏ Iron Stain Only

❏ BONE MARROW
Leukemia Immunoflow Cytometry

❏ BONE MARROW CHROMOSOMES

❏ GROSS ONLY

Notice to Physicians:
Diagnosis codes must be provided for each test ordered. Only tests you believe are appropriate for patient care should be ordered. Medicare will only pay for tests that are medically necessary for the diagnosis and treatment of the patient. Medicare does not generally cover routine screening tests.

PRE OP DIAGNOSIS: ______________________

POST OP DIAGNOSIS: ______________________

CLINICAL HISTORY: ______________________

DOB: ___/___/_____ Pt. Full Name: ______ Collect: _____/_____ ____:____ Site/Source: ______

DOB: ___/___/_____ Pt. Full Name: ______ Collect: _____/_____ ____:____ Site/Source: ______

DOB: ___/___/_____ Pt. Full Name: ______ Collect: _____/_____ ____:____ Site/Source: ______

DOB: ___/___/_____ Pt. Full Name: ______ Collect: _____/_____ ____:____ Site/Source: ______

DOB: ___/___/_____ Pt. Full Name: ______ Collect: _____/_____ ____:____ Site/Source: ______

DOB: ___/___/_____ Pt. Full Name: ______ Collect: _____/_____ ____:____ Site/Source: ______

_____ Vial
_____ Slide
_____ L-LAV
_____ Micro
FOR OFFICIAL USE ONLY
___/___/___

SOURCE 4 • TO REORDER CALL (804) 794-5923

172281

IRL-C (Rev. 09/17)

Form# IRL-C; rev. 09/2017

2062645.indd 3 10/4/17 9:09 AM

445260176300

445260176300

445260176300

445260176300