Inova™ Laboratories

400000018001

2832 JUNIPER STREET • FAIRFAX, VA 22031

Specimen Pickup - Lab Results (703) 645-6175

Inova.org/labs

Date Collected:	Time Collected:	Collected By:	Time Centrifuged:

ATTACH INSURANCE CARDS

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

PATIENT LAST NAME	FIRST NAME	MI

SEX (M-Male F-Female)	DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY #	PHONE	RACE
	— —	— —	— —	

ADDRESS	CITY	STATE	ZIP

PRIMARY BILLING PARTY

INSURANCE CARRIER

POLICY #

GROUP#/ENROLLMENT CODE

INSURANCE ADDRESS

SUBSCRIBER SUBSCRIBER'S DATE OF BIRTH

❑ **FAX TO** _____

_____

ORDERING PHYSICIAN

Physician's Name _____

LAST FIRST

ATTACH INSURANCE CARDS

HISTOPATHOLOGY

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

PHYSICIAN'S SIGNATURE: _____

❑ **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: _____

_____

400000018001 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____	400000018001 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____	400000018001 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____
400000018001 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____	400000018001 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____	400000018001 DOB: ___/___/___ Pt. Full Name: _____ Collect: ____/____ ____:____ Site/Source: _____

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

___/___/___


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