

4800 SW 35th Dr., Gainesville, FL 32608

**Complete For All Patients**

Patient Name (Last)	(First)	(M.I.)	Patient ID #	Date of Birth / /	Sex M F
Street Address		City	State	Zip	Patient Phone
Ordering Physician	Duplicate Report Sent To:		Bill To: <input type="checkbox"/> Client <input type="checkbox"/> Patient <input type="checkbox"/> Insurance <input type="checkbox"/> Mcare/Mcaid		

**Complete To Bill Third Party**

Primary Insurance Name	Address	City	State	Zip
Subscriber ID #	Group #	Subscriber Name		DOB
Secondary Insured Name	Address	City	State	Zip
Subscriber ID #	Group #	Subscriber Name		DOB
Patient relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			Collection Date/Time:	

**Physicians**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICD-9	ICD-9	ICD-9	ICD-9	

**Tissue Pathology**

Skin Biopsy  GI Biopsy  Cervical Biopsy  Prostate Biopsy  Breast Biopsy  Renal Biopsy  Muscle Biopsy  Other \_\_\_\_\_

Description: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Clinical History: \_\_\_\_\_  
 \_\_\_\_\_

Endocrine/Autoantibody	Endocrine/Autoantibody	Quantitive Pathology	Molecular Biology
<input type="checkbox"/> 0017 Islet Cell Autoantibody <input type="checkbox"/> 0018 Insulin Autoantibody <input type="checkbox"/> 0019 Thyroid Microsomal Autoantibody <input type="checkbox"/> 0020 Thyroglobulin Autoantibody <input type="checkbox"/> 0021 Gastric Parietal Cell Autoantibody <input type="checkbox"/> 0022 Adrenal Autoantibody <input type="checkbox"/> 0039 Ovarian Autoantibody <input type="checkbox"/> 0040 Testicular Autoantibody <input type="checkbox"/> 0108 Placental Autoantibody <input type="checkbox"/> 0277 Glutamic Acid Decarboxylase Autoantibody <input type="checkbox"/> 0278 IA-2 Autoantibody <input type="checkbox"/> 0162 Islet Cell/Insulin Autoantibody <input type="checkbox"/> 0023 Steroidal Autoantibody Panel (Adrenal/Ovarian/Testicular/Placental Autoantibodies)	<input type="checkbox"/> 0024 Endocrine Autoantibody Panel (Islet Cell/Thyroid Microsomal/Thyroglobulin/Gastric Parietal/Adrenal/Ovarian/Testicular/Placental) <input type="checkbox"/> 0291 Autoimmune Diabetes Autoantibody w/o IAA (GAD, IA2, ICA) <input type="checkbox"/> 0292 Autoimmune Diabetes Autoantibody w/ IAA (GAD, IA2,ICA,IAA) <b>Coagulation</b> <input type="checkbox"/> 0219 Heparin-Platelet Autoantibody <input type="checkbox"/> 0032 Anti-cardiolipin IgG & IgM <input type="checkbox"/> 0114 Antiphosphotidylserine Ab IgG & IgM <input type="checkbox"/> 0229 Anti-Beta2 Glycoprotein IgG & IgM <input type="checkbox"/> 0206 Factor V Leiden Mutation <input type="checkbox"/> 0258 Prothrombin/20210 Mutation <input type="checkbox"/> 0276 MTHFR	<input type="checkbox"/> 0060 DNA/Paraffin Block <input type="checkbox"/> 0126 Morphometry-Tumor <input type="checkbox"/> 0136 Estrogen Receptor <input type="checkbox"/> 0137 Progesterone Receptor <input type="checkbox"/> 0138 HER-2/neu <input type="checkbox"/> 0281 HER-2/neu FISH <input type="checkbox"/> Morphometry-abnormal placental tissue (DNA ploidy/p57) <input type="checkbox"/> 0142 Comprehensive Breast Panel (ER/PR/HER-2 neu/Ki67/DNA ploidy) <input type="checkbox"/> 0141 Ki67 (MIB-1) <input type="checkbox"/> ER/PR <input type="checkbox"/> ER/PR/HER-2 <input type="checkbox"/> ER/PR/HER-2/Ki-67 <input type="checkbox"/> 0295 1p/19q FISH	<input type="checkbox"/> 0248 bcl-2 Translocation mcr/MBR <input type="checkbox"/> 0252 T-Cell Clonality <input type="checkbox"/> 0256 B-Cell Clonality <input type="checkbox"/> 0814 HCV Genotyping <input type="checkbox"/> 0804 HCV Viral Load <input type="checkbox"/> Microsatellite Instability <input type="checkbox"/> UroVysion <input type="checkbox"/> Urovysion only <input type="checkbox"/> Cytology & Urovysion Type: <input type="checkbox"/> Voided <input type="checkbox"/> Catheterized <input type="checkbox"/> Bladderwash <input type="checkbox"/> Other: _____ <input type="checkbox"/> KRAS

**Non-GYN Cytology**

Breast Smear  FNA \_\_\_\_\_  Body Cavity Fluid (specify) \_\_\_\_\_  Pulmonary (specify type) \_\_\_\_\_

Bladder Washing  Urine  Other \_\_\_\_\_

Clinical History : \_\_\_\_\_  
 \_\_\_\_\_

Lab Use Only: \_\_\_\_\_

**PERMISSION FOR TREATMENT AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:**

Authorization is given to University of Florida Diagnostic Reference Laboratories to release any information including examination, diagnosis and treatment, to my insurance carrier.

I request my insurance carrier to pay University of Florida Diagnostic Reference Laboratories benefits due me related to my pending claim for medical and surgical services.

My signature is on the front side of this form.