BIOPSY REQUEST FORM

Ordering Physician (please print): _____

Physician Phone Number: _____

Procedure Requested: _____

Patient Name: _____

Patient D.O.B. _____ **Phone(s):** _____

ICD-10/Reason for Biopsy: _____

Has the patient had a recent CT, US, or MRI: _____ **Yes** _____ **No**

Blood Thinners? ☐ **Yes** ☐ **No** **Aspirin?** ☐ **Yes** ☐ **No**
If yes, can patient be off for 7 days? ☐ **Yes** ☐ **No**

Latex Allergy ☐ **Yes** ☐ **No** **Contrast Allergy** ☐ **Yes** ☐ **No**

NOTE

The biopsy request form will not be submitted to the Radiologist without the following: Images (If not performed at LCMH), Current H&P (Expires within 30 days of submitting this request), and lab order for day of biopsy.

Additional Information for Radiologist: _____

_____

_____

_____

TO BE COMPLETED BY RADIOLOGY:

Images in PACS: _____ Yes _____ No

Type of Anesthesia: _____ Moderate _____ General _____ None

Exam Date/Time _____

APPROVED: _____ **DENIED:** _____

Reason for Denial: _____

Scheduler: _____ Date Submitted: _____

Approving Radiologist: _____ Date Signed Off: _____