Lake Charles
Memorial Health System

BIOPSY REQUEST FORM

Phone: 337.494.3070 | Fax: 337.494.6524 | Email: radiologyorders@lcmh.com

Ordering Physician (please print):_____

Physician Phone Number:_____

Procedure Requested:_____

Patient Name:_____

Patient DOB:_____ Patient Phone:_____

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: _____