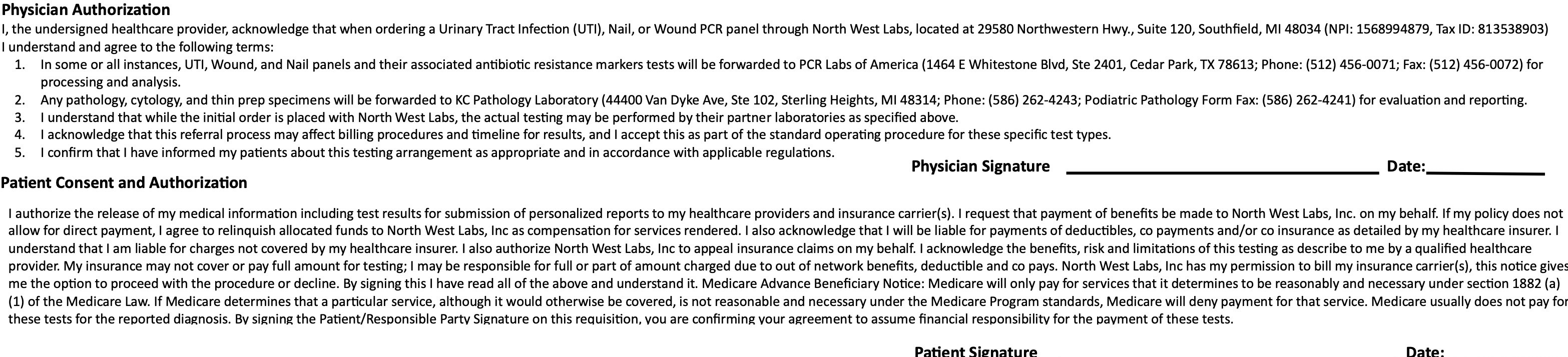
North West Labs



**Other Tests/Panels:**

***For a full menu of testing, please visit www.mdlab***

**ICD10 codes (required):**

29580 Northwestern Hwy,

Southfield, MI 48034

(248) 301-6917

**Gastrointestinal (GI) Test Requisition Form**

**Patient Information (Please Print)**

**Ordering Physician/Laboratory**

|  |  |
| --- | --- |
| (Required: Include the ordering physician’s first & last name, NPI, practice name, complete address, phone number and fax number.) | |
| Physician to receive additional result report: | |
| Physician’s Signature: | Date: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name (Last, First) (Required): | | | | | |
| In Care of: | | | | | |
| Patient Address: | | | | | |
| City: | | State: | Zip: | | |
| Assigned Sex at Birth (Required):  □Female □Male | Date of Birth (Required): | | | | Patient ID#: |
| Phone Number: □ □ CHeolml PehPohnoene | | | | | |
| **R**B**a**la**c**c**e**k**:** o□r **A**flraicsakna ANmateivriecaonr American Indian □ Asian □  □ Multiracial □ Native Hawaiian or other Pacific Islander  □ Other race □ White □ Does not wish to disclose □ Not provided | | | | **Ethnicity:** □ Hispanic or Latino   * Not Hispanic or Latino * Unknown | |
| **Gender Identity:** □Male □ Female □Gender nonconforming □Transgender male-to-female  □Transgender female-to-male □ Does not wish to disclose □Not provided □ Not applicable | | | | | |
| **Sexual Orientation:** □Bisexual □Straight □Gay or Lesbian □Something else □ Does not wish to disclose □ Not provided □ Not applicable | | | | | |

GI Panel

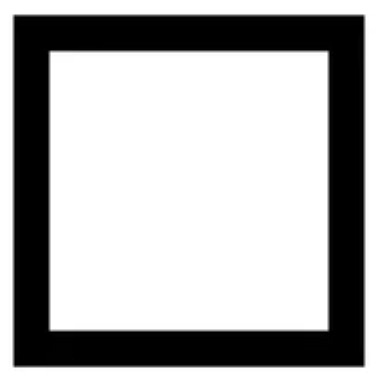
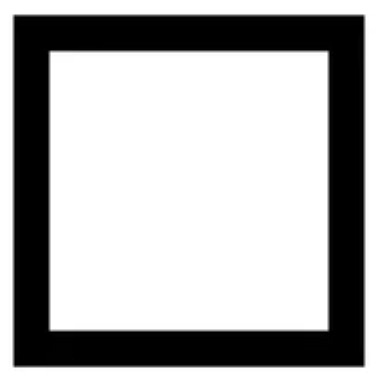
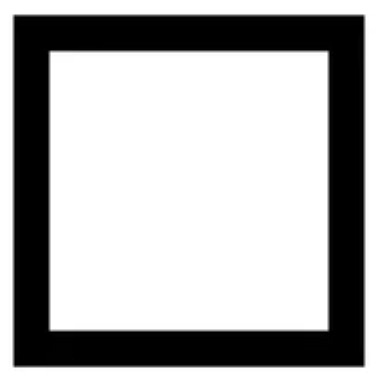
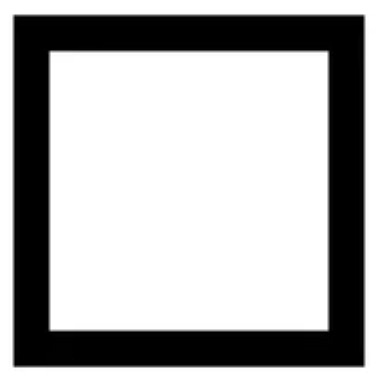
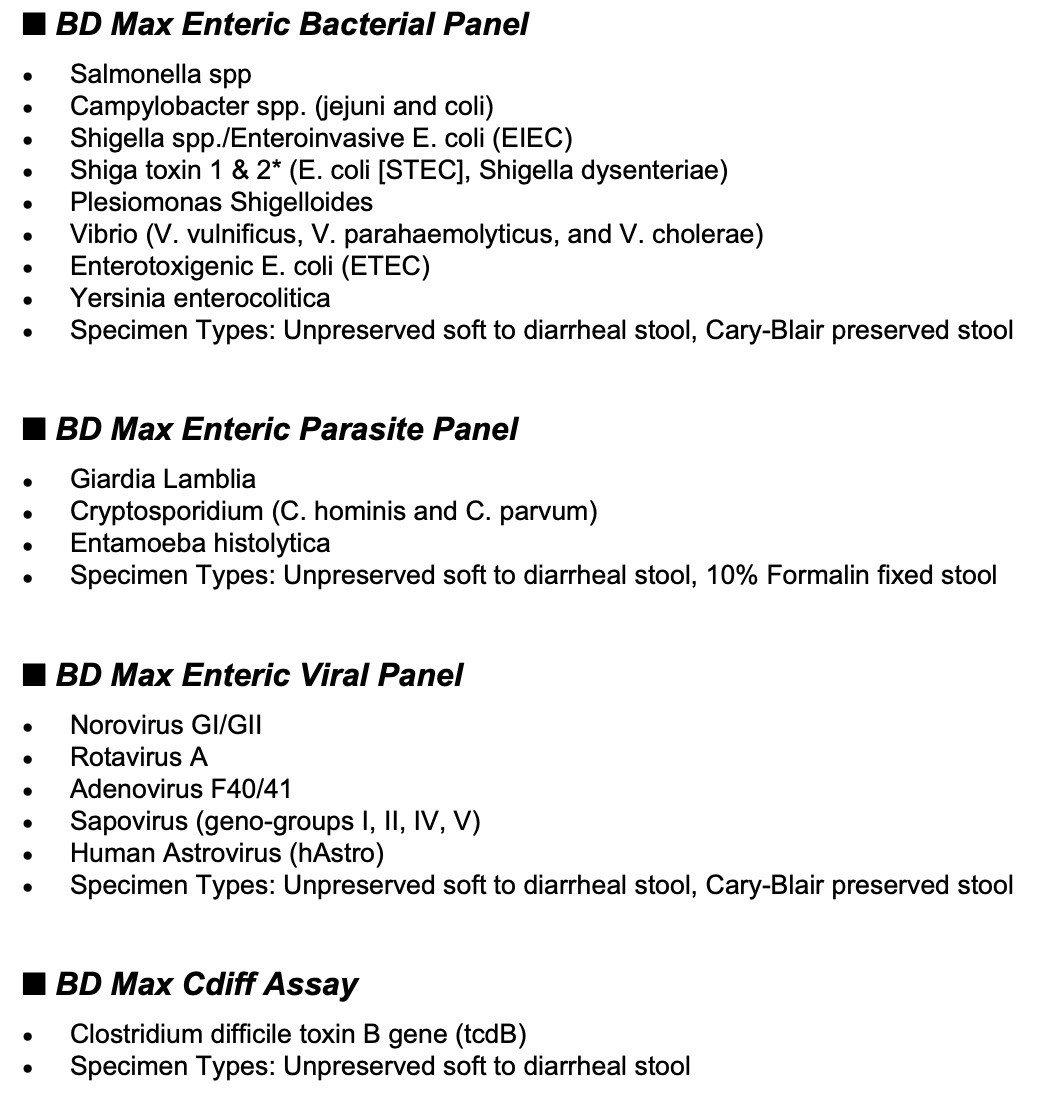
***OneSwab®* Speci**

**en Information**

Date Collected (Req.): Sp

ecimen Source:  ***OneSwab®***:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Biopsy Information**



**Billing Information (Please include a copy of the front & back of card.)**

Billing Type: □Relation (Required): □Self □Spouse □Dependant Patient □ Insurance □ Client Insured’s Name (if not patient):

Insured’s SS#:

Insured’s DOB:

**m**

Group#:

Employer/Group Name:

Claims Address:

Medicare, Medicaid or Policy ID#:

Primary Insurance Carrier:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **ICD10 codes (required):`** | | | | | | | |
| Date Collected (Req.): | Time Collected: | | | Collector Signature: | | No. vials collected: | |
| **Type:**  □Adenoma □Crohn’s □*H. pylori* □Microscopic Colitis  □Barrett’s Esophagus □Dysplasia □Hepatitis □Proctitis  □Cancer □Eosinophilic Esophagitis □IBD □Sprue  □Candida □Fungi □Lymphoma □Steatohepatitis  □Other: | | | | | | | |
| **Endoscopic Finding Code:**   1. Normal 6. Friable 11. Hemorrahgic 16. Polyposis 2. Edema 7. Abn. Vascular Pattern 12. Erosion 17. Mass 3. Barrett’s Mucosa 8. Hyperemia 13. Ulcer 18. Submucosal Nodule 4. Granular 9. Telangiectactic 14. Stricture 19. Pseudomembrane 5. Nodular 10. Punctate Hemorrhage 15. Polyp 20. Other: | | | | | | | |
| **Anatomic Site of Biopsy: Container** | | | **Organ & Site** | | **Distance (cm)** | | **Endoscopic Finding (see codes above)** |
| 1. | | |  | |  | |  |
| 2. | | |  | |  | |  |
| 3. | | |  | |  | |  |
| 4. | | |  | |  | |  |
| 5. | | |  | |  | |  |
| 6. | | |  | |  | |  |
| 7. | | |  | |  | |  |
| 8. | | |  | |  | |  |
| **Special Stains For:**   * *H. pylori* Fungus | | * TB Virus Other: | | | | | |