Your Hospital's Logo Here

OUTPATIENT ENDOSCOPY BIOPSY REQUISITION

PATIENT IDENTIFICATION

NAME:	DATE OF BIRTH:	PROCEDURE DATE:
SEX: ☐ M ☐ F — ADDRESS:		
CITY:	STATE:	ZIP:
REQUESTING PHYSICIAN:	INSURANCE COMPANY:	POLICY #:

CLINICAL INFORMATION

- ☐ PAIN
- ☐ BLEEDING
- ☐ REFLUX
- ☐ WEIGHT LOSS
- ☐ POSITIVE STOOL
- ☐ INFLAMMATORY BOWEL DISEASE
- ☐ HEPATITIS TYPE _____
- ☐ OTHER _____

CLINICAL DIAGNOSIS:

PROCEDURE PERFORMED:

SOURCE

- ☐ ESOPHAGUS
- ☐ E-G JUNCTION
- ☐ GASTRIC FUNDUS
- ☐ GASTRIC BODY
- ☐ GASTRIC ANTRUM
- ☐ PYLORUS
- ☐ DUODENUM
- ☐ JEJUNUM
- ☐ ILEUM
- ☐ LIVER BIOPSY
- ☐ OTHER _____

COLON: ☐ BIOPSY / ☐ POLYPECTOMY

- ☐ CECUM
- ☐ ASCENDING COLON
- ☐ HEPATIC FLEXURE
- ☐ TRANSVERSE COLON
- ☐ SPLENIC FLEXURE
- ☐ DESCENDING COLON
- ☐ SIGMOID
- ☐ RECTUM
- ☐ OTHER _____

RULE OUT

- ☐ BARRETT'S
- ☐ H. PYLORI GASTRITIS
- ☐ INFLAMMATORY BOWEL DISEASE
- ☐ ENTEROPATHY
- ☐ NEOPLASM
- ☐ COLLAGENOUS -or- MICROSCOPIC COLITIS
- ☐ PARASITES
- ☐ OTHER _____

CPT CODES

- ☐ 88305 _____
- ☐ 88307 _____
- ☐ 88309 _____
- ☐ 88312 _____
- ☐ 88313 _____
- ☐ 88342 _____
- ☐ OTHER _____
- ☐ OTHER _____
- ☐ OTHER _____

PATHOLOGIST: M.D.	DATE:	SPEC #:

PART OF THE MEDICAL RECORD