VANTAGEPOINT
LABORATORY PARTNERS

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GASTROENTEROLOGY REQUISITION

Account/Physician

LABEL SPECIMENS WITH NUMBERS

XXXXX	XXXXX
XXXXX	XXXXX
XXXXX	XXXXX

PATIENT LAST NAME	FIRST	MI	BIRTHDATE	SEX
STREET ADDRESS			PLEASE ATTACH COPY OF PATIENT'S INSURANCE CARD	
CITY	STATE	ZIP	PHONE #	
GUARANTOR'S NAME	STREET ADDRESS	CITY / STATE / ZIP	PHONE #	

BILL: ☐ PATIENT ☐ PHYSICIAN ☐ INSURANCE ☐ MEDICARE ☐ MEDI-CAL — MRN/SSN #

INS. CO. NAME	SUBSCRIBER NAME	MEMBER ID #
GROUP #	INS. ADDRESS	

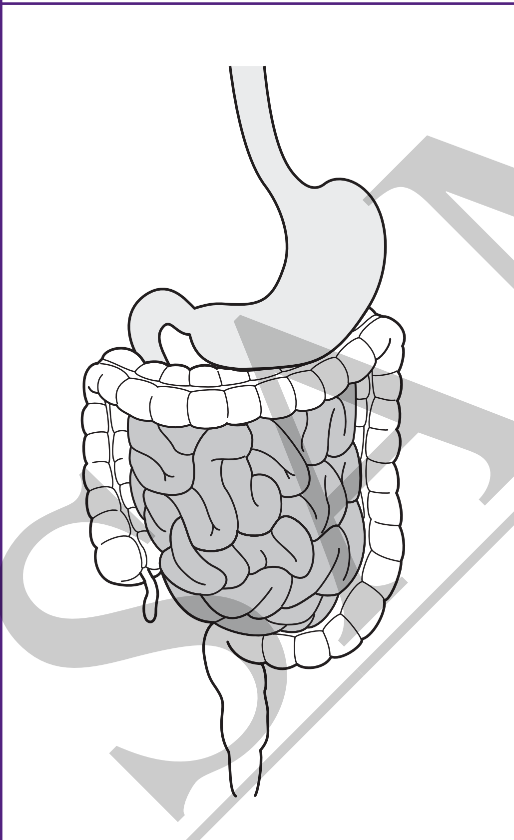
ICD-9 Codes **(required)**

CC PHYSICIAN add fax) — REQUESTOR SIGNATURE

SAMPLE

SPECIMEN/CLINICAL INFORMATION

Date Specimen Collected: ________________ Time Specimen Collected: ________________ Total # of Vials: __________



SPECIMEN SITE:

1: ____________________
2: ____________________
3: ____________________
4: ____________________
5: ____________________
6: ____________________
7: ____________________
8: ____________________
9: ____________________
10: ____________________

CLINICAL HISTORY / DIFFERENTIAL DIAGNOSIS

☐ Cancer Screening
☐ History of Polyps/cancer
☐ Upper GI Bleeding
☐ Lower GI Bleeding
☐ Nausea/vomiting
☐ Dysphagia
☐ Diverticular Disease
☐ Reflux
☐ Heartburn
☐ History of Ibd
☐ Malabsorption
☐ Travel History
☐ Other: ____________________

Diarrhea
☐ Bloody
☐ Watery
☐ Mucoid

ENDOSCOPIC FINDINGS

☐ Normal / Unremarkable
☐ Inflamed
☐ Ulcerated
☐ Barett's
☐ Salmon Patch
☐ Hiatal Hernia
☐ Irregular Z Line
☐ Fissures
☐ Mass Lesion
☐ Possible Polyp
☐ Obvious Polyp
☐ Pseudomembranes
☐ Atrophic
☐ Hemorrhagic
☐ Possible Submucosal Lesion
☐ Other: ____________________

SPECIAL INSTRUCTIONS: ____

Attention Physician

Patient, Client and Billing Information is requested for the timely processing of this case. Medicare, Medi-cal and other third party payors require that tests be medically necessary.