PRECISION PATHOLOGY
"A Spirit of Excellence"

Lab Use Only:
Tech Initial: _____
Accession #: _____
Date/Time: _____

MICROBIOLOGY REQUISITION

PATIENT INFORMATION

Last Name	First Name	M.I.
Street Address		Apt. #
City	State	Zip
Patient Phone Number	Patient Social Security Number	
Date of Birth / /	Age	Sex	Client ID #

BILLING / INSURANCE (or attach copy of insurance card - both sides)

Bill:
- ☐ Insurance
- ☐ Medicare
- ☐ Medicaid
- ☐ Worker's Comp
- ☐ Patient
- ☐ Physician
- ☐ Hospital
- ☐ Other

- ☐ Inpatient
- ☐ Outpatient
- ☐ Emergency Room

Insurance ☐ Secondary Insurance Information Attached

Name/Relationship to Insured: ☐Self ☐Spouse ☐Dependent

Company Name

Address

City	State	Zip

Employer Name

Group/Contract #	Member ID #
Medicare #	Medicaid ID #

CLIENT INFORMATION

Treating Physician	UPIN #

Physician's Signature X _____

Send Duplicate of Report to:

Name _____

Address/Fax _____

ICD-9 CODE (Required) _____

SPECIMEN SITE

HISTORY AND CLINICAL DIAGNOSIS

SPECIMENS

Collection Date: _____ Collection Time: _____

ROBY P. JOYCE, MD, FCAP, FASCP PATRICIA G. JEFFREYS, MD, FCAP

12315 JUDSON RD., STE. 114 • LIVE OAK, TX 78233
TEL: 210-646-0890 • FAX: 210-646-9191
www.precisionpath.us • CAP No. 7221111

PPS COPY