PRECISION PATHOLOGY
"A Spirit of Excellence"

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

HOSPITAL PATHOLOGY REQUISITION

PATIENT INFORMATION / PATIENT STICKER

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

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

☐ Insurance Information is Attached

☐ Inpatient ☐ Outpatient

ICD-9 CODE (Required) _____

COMMENTS

SPECIMEN SITE

CLIENT INFORMATION

Operating Room # _____

Surgeon _____

Send Duplicate of Report to:

Name _____

Address/Fax _____

PRE-OPERATIVE DIAGNOSIS

POST-OPERATIVE DIAGNOSIS

SPECIMENS

Collection Date: _____ **Cold Ischemic Time:** _____ **Fixation Time:** _____

A _____ E _____

B _____ F _____

C _____ G _____

D _____ H _____

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