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

SURGICAL PATHOLOGY 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

COMMENTS / RULEOUTS

SPECIMENS

Collection Date: ______ Cold Ischemic Time: ______ Fixation Time: ______

A ______ E ______

B ______ F ______

C ______ G ______

D ______ H ______

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