HOSPITAL PATHOLOGY REQUISITION

Lab Use Only:
Tech Initial: ______
Result ID: ______
Date/Time: ______

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 #
/ /			

CLIENT INFORMATION

Operating Room # ______

Surgeon ______

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

☐ Insurance Information is Attached

☐ Inpatient ☐ Outpatient ☐ Bill Physician Facility

ICD-10 CODE (Required)

COMMENTS/RULE OUTS

Send Duplicate of Report to:

Name ______

Address/Fax ______

CLINICAL HISTORY

SPECIMENS

Collection Date and Time: ______ Fixation Time: ______

A______ E______

B______ F______

C______ G______

D______ H______

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