PRECISION PATHOLOGY
"A Spirit of Excellence"

SURGICAL PATHOLOGY REQUISITION

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

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)

☐ Insurance Information is Attached

☐ Inpatient ☐ Outpatient ☐ Bill Physician Facility

ICD-10 CODE (Required)

COMMENTS

CLIENT INFORMATION

Treating Physician	UPIN #

Physician's Signature X _____

Send Duplicate of Report to:

Name _____

Address/Fax _____

HISTORY AND CLINICAL DIAGNOSIS

COMMENTS / RULEOUTS

SPECIMENS

Collection Date and Time: _____ Fixation Time: _____

A _____ E _____

B _____ F _____

C _____ G _____

D _____ H _____

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