PRECISION PATHOLOGY
"A Spirit of Excellence"

HOSPITAL PATHOLOGY REQUISITION

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

PPS Accessioning Department Only

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 ☐ Bill Physician Facility

ICD-10 CODE (Required)

NOTICE

For the following diagnoses, biomarker testing will be performed, per NCCN and CAP/ASCO guidelines: Breast adenocarcinoma (ER/PR/HER2); Colorectal cancer (MMRd by IHC); Adeno NSCLC (PD-L1, EGFR mutation analysis).

COMMENTS/RULE OUTS

CLIENT INFORMATION

Operating Room # _____

Surgeon _____

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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