



SURGICAL PATHOLOGY REQUISITION

PPS Use Only:

Tech Initial: _____

Result ID: _____

Date/Time: _____

**PPS
Accessioning
Department
Only**

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 #	

CLIENT INFORMATION	

BILLING / INSURANCE <small>(or attach copy of insurance card - both sides)</small>
<input type="checkbox"/> Insurance Information is Attached <input type="checkbox"/> Bill Physician Facility

ICD-10 CODE (Required)

NOTICE
<p>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).</p>

COMMENTS / RULEOUTS

Treating Physician	UPIN #
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Physician's Signature X _____

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 _____

LILIA WOJCIK, MD, FCAP
PEGGY N. STOLL, MD, FCAP, FASCP

ROBY P. JOYCE, MD, FCAP, FASCP
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HOWARD WEISBROD, MD, FCAP



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