



SURGICAL PATHOLOGY REQUISITION

PPLS Use Only:

Tech Initial: _____

Result ID: _____

Date/Time: _____

**PPLS
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	
Client Name:	_____
Address:	_____
City, State, Zip:	_____
Phone:	_____
Fax:	_____
Email:	_____

BILLING / INSURANCE <small>(or attach copy of insurance card - both sides)</small>
<input type="checkbox"/> Bill Patient Insurance <i>(Attach copy of insurance card, both sides)</i> <input type="checkbox"/> Bill Patient directly / No insurance <input type="checkbox"/> 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 / 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 VIBHA BHASIN, MD, FCAP, FASCP	ROBY P. JOYCE, MD, FCAP, FASCP JAMES HUMPHREYS, MD, FCAP	PATRICIA G. JEFFREYS, MD, FCAP LINDA HAUSENFLUKE, MD, FCAP, FASCP HOWARD WEISBROD, MD, FCAP
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