PRECISION PATHOLOGY LABORATORY
"A Spirit of Excellence"

HOSPITAL PATHOLOGY REQUISITION

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

PPLS 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 ❒ Patient Bill
❒ 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

Client Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Email: _____

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 _____

LILIA WOJCIK, MD, FCAP
LINDA HAUSENFLUKE, MD, FCAP, FASCP
VIBHA BHASIN, MD, FCAP, FASCP

ROBY P. JOYCE, MD, FCAP, FASCP
JAMES HUMPHREYS, MD, FCAP

PATRICA G. JEFFREYS,MD, FCAP
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