corePATH LABORATORIES

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Surgical Pathology Requisition

REQUIRED ITEMS

1. CBC 2. Clinical Information 3. ICD 10 Codes 4. Face Sheet (Front and Back Copy of the Patient's Insurance Card and Demographic Information) 5. Provider's Signature

PATIENT INFORMATION

Last Name ______________________

First Name ______________________ M.I. ________

DOB ______/______/______ Gender: ☐ Male ☐ Female ☐ Other ________

Address ______________________

City ______________ State ________ Zip ____________

Phone ______________ Patient ID ____________

PROVIDER INFORMATION

Authorized Signature Date

Please Fax Duplicate Report to Provider Fax

BILLING INFORMATION

Bill to: ☐ Insurance ☐ Medicare ☐ Referring Facility (Hospital/Client) ☐ Split Billing - Client (TC) and Insurance (PC) ☐ Patient

Patient Status: ☐ Inpatient (Hospital) ☐ Outpatient (Hospital) ☐ Non-Hospital ☐ ASC Prior Authorization # ____________

CLINICAL INFORMATION

Indication(s) for Testing: ______________________

____

ICD-10 Codes: ______________________ Disease: ☐ New Diagnosis ☐ Refractory ☐ Recurrent/Relapsed ☐ Follow-Up

PRE-OP DIAGNOSIS

____

____

POST-OP DIAGNOSIS

____

____

SPECIMEN INFORMATION

Date Collected ________/________/________

Time Placed in Formalin (Breast Only) ______:______ ☐ AM ☐ PM

Date Retrieved ________/________/________

Date Discharged ________/________/________

Specimen ID ______________________

SPECIMEN TYPE

☐ Biopsy ☐ Culture
☐ FNA ☐ Submitted Fresh
☐ Cytology

Other: ______________________

SKIN ONLY

☐ Punch ☐ Shave
☐ Curettage ☐ Excision

Other: ______________________

SPECIMEN SITES (FOR MORE TESTING INFORMATION, VISIT COREPATH.US)

A		H	
B		I	
C		J	
D		K	
E		L	
F		M	
G		N	

LABORATORY USE ONLY