COREPATH

Surgical Pathology Requisition

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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 Provider Signature Date

Please Fax Duplicate Report to Additional 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