Surgical Pathology Requisition

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PATIENT INFORMATION

Last Name _____

First Name _____ M.I. _____

DOB ____/____/____ Gender: ☐ Male ☐ Female ☐ Other _____

Address _____

City _____ State _____ Zip _____

Phone _____ Patient ID _____

BILLING INFORMATION

Required: Please attach a copy of the patient's insurance and demographic information.

Bill to: ☐ Insurance ☐ Medicare ☐ Referring Facility (Hospital/Client) ☐ Patient

Patient Status: ☐ Inpatient ☐ Outpatient ☐ Non-hospital patient ☐ ASC

PROVIDER INFORMATION

Authorized Signature | Date

Please Fax Duplicate Report to Provider | Fax

PRE-OP DIAGNOSIS

_____

_____

POST-OP DIAGNOSIS

_____

_____

CLINICAL INFORMATION

Please provide pertinent clinical history and ICD 10 Codes.

SPECIMEN INFORMATION

Date Collected ____/____/____ Time Placed in Formalin (Breast Only) ____:____ ☐ AM ☐ PM Specimen ID _____

SPECIMEN TYPE

☐ Biopsy ☐ FNA ☐ Cytology ☐ Culture ☐ Submitted Fresh Other _____

SKIN ONLY

☐ Punch ☐ Curettage ☐ Shave ☐ Excision Other _____

SPECIMEN SITES

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

LABORATORY USE ONLY