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GENERAL PATHOLOGY REQUISITION

FACILITY:

PHYSICIAN(S):

Medicare/Medicaid Authorized
Physician /Practitioner signature (REQUIRED)

DATE COLLECTED:

PATIENT INFORMATION:

Last Name First Name M.I.

Address

City State Zip Code

Laboratory use only

Accession#

Date Received

Age Sex Date of Birth Patient I.D. # Social Security #

SOURCE OF TISSUE:

PERTINENT CLINICAL INFORMATION/PREOPERATIVE DIAGNOSIS:

BILLING INFORMATION:

Medicaid # Medicare #

OTHER INSURANCE:

Name Policy #

Address Group #

Policy Holder's Name Employer

IF THIS FORM IS NOT FULLY COMPLETED, THE PROCESSING OF THIS SPECIMEN WILL BE DELAYED
SPECIMEN TO BE PLACED IN 10% FORMALIN AS SOON AS OBTAINED

R Fx c/om