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Laboratory use only

GENERAL PATHOLOGY REQUISITION

Date:

PATIENT INFORMATION:

Last Name First Name Middle Name Social Security No.

Address Physician Name

City State Zip Code Medicare/Medicaid Authorized Physician /Practitioner signature (REQUIRED)

Age Sex Date of Birth Physician Address

SPECIMEN TYPE AND INSTRUCTIONS (USE EXTRA SHEET IF MORE THAN FOUR SPECIMENS)

SPECIMEN 1 M Shave biopsy M Punch biopsy M Excision M Re-excision M Needle biopsy M Endoscopic biopsy M Other (specify) _____	**SOURCE OF TISSUE:**	**PERTINENT CLINICAL INFORMATION:** **CLINICAL DIFFERENTIAL DIAGNOSIS:**
SPECIMEN 2 M Shave biopsy M Punch biopsy M Excision M Re-excision M Needle biopsy M Endoscopic biopsy M Other (specify) _____	**SOURCE OF TISSUE:**	**PERTINENT CLINICAL INFORMATION:** **CLINICAL DIFFERENTIAL DIAGNOSIS:**
SPECIMEN 3 M Shave biopsy M Punch biopsy M Excision M Re-excision M Needle biopsy M Endoscopic biopsy M Other (specify) _____	**SOURCE OF TISSUE:**	**PERTINENT CLINICAL INFORMATION:** **CLINICAL DIFFERENTIAL DIAGNOSIS:**
SPECIMEN 4 M Shave biopsy M Punch biopsy M Excision M Re-excision M Needle biopsy M Endoscopic biopsy M Other (specify) _____	**SOURCE OF TISSUE:**	**PERTINENT CLINICAL INFORMATION:** **CLINICAL DIFFERENTIAL DIAGNOSIS:**

M **CULTURES SENT**

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