REQUISITION FORM

Anatomic Pathology

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PART A: Patient Information - *Required*

Patient Name:_____

Date of Birth_____ Gender M____F____

Address:_____

City_____ State_____ Zip Code_____

Social Security:_____ EMR#_____

Specimen collection date:_____

PART B: Provider Information - *Required*

Provider:_____

Address: _____

City_____ State_____ Zip Code_____

Phone:_____ Fax:_____

NPI#_____ Signature_____

Send Duplicate Report to: Name_____ Address/Fax_____

PART C: Indications/Clinical History: _____

_____

ICD-10 Code (*Required*): 1)_____ 2)_____ 3)_____ 4)_____

PART D: Insurance Billing Information: *Send Bill to:* Patient:____ Insurance:____

Name of Primary Insurance CO _____ Insured ID _____ Group # _____

Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other ☐

Insured's Name _____ Insured Date of Birth _____/_____/_____

Please Attach: 1) A copy of the front/back of patient's insurance card(s) or 2) Printout patient demographics and insurance information from your EHR

PART E: Biopsy Specimen Information: # of Container:_____

A:_____ **D:**_____ NOTE:

B:_____ **E:**_____

C:_____ **F:**_____

PART F: Cytology Specimen Information: # of Container:_____ # of slides:_____

1: Urine_____ Void:_____ Instrument:_____ (*Please submit in sterile urine container or Cytolyte*)

2: Thyroid_____ Site A:_____ Site B:_____ Site C:_____

(*Please prep 1-2 airdried slide and make additional passes to put in Cytolyte*)

3: Breast:_____ Site A:_____ Site B:_____ Cystic:_____ Solid:_____

(*Please put all aspiration material in Cytolyte*)

4: Other:_____ Site:_____ (*Please prep 1-2 airdried slide and make additional passes to put in Cytolyte*)

FOR LAB USE ONLY:

Receiving Date:_____ Time:_____ Accession#_____ Note:_____