SURGICAL PATHOLOGY REQUISITION

INTEGRATED PATHOLOGY

SCIENTIFIC DIAGNOSES AND LABORATORY SOLUTIONS

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RESET FORM

CLIENT INFORMATION:

PATIENT INFORMATION

Patient Name: _____
(LAST, FIRST)

DOB: _____ Age: _____ Gender: ☐ Male ☐ Female

Street Address: _____

City: _____ State:_____ Zip Code: _____

Patient ID #: _____ SSN#: _____

Submitting Physician: _____

Patient Phone #:_____ Referring Physician: _____

Date of Collection:_____ Time of Collection: _____

BILLING INFORMATION

Please provide the current ICD-10 code(s): _____

Please complete billing information below or attach a separate sheet and a copy of insurance card with the necessary information:

Insurance Company State Name of Employer

_____

Policy No. Group No.

_____

Insurance Company Street Address City State Zip Code

_____

Name of Insured (if other than patient):_____

Patient's relationship to insured: ☐ Spouse ☐ Child ☐ Other, Explain

IP Pathologists may order additional testing based on medical necessity.

CLINICAL DATA & SPECIAL INSTRUCTIONS

Previous surgery: ☐ Yes ☐ No Previous Therapy: ☐ Chemotherapy ☐ Radiation ☐ Hormonal therapy ☐ Other:_____

Previous biopsy: ☐ Yes ☐ No

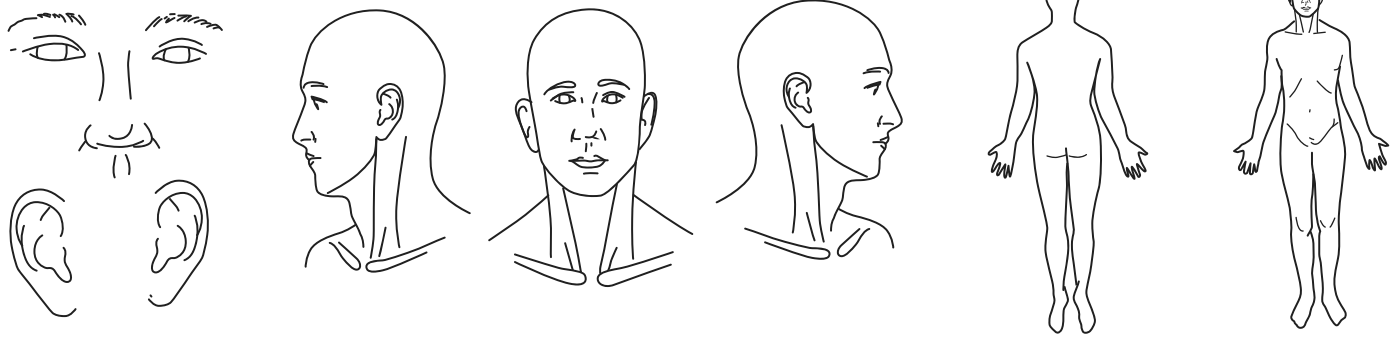
Previous diagnosis: ☐ Yes ☐ No --- If Yes, Specify diagnosis: _____

Additional Pertinent Medical History:

Special Instructions:

SPECIMENS

Specimen	Specimen Designation	Anatomic Location	Surgical Procedure
A			
B			
C			
D			
E			
F			



IPS USE ONLY: Received Date & Time: Assigned Case #: