

Facility Name

Facility Address

Facility Phone Number

Provider Full Name

Provider NPI

SURGICAL PATHOLOGY REQUEST		
LAST NAME	FIRST NAME	MI
DATE OF BIRTH	RACE	SEX
SOCIAL SECURITY NUMBER		
PATIENT ID#		

STAT DUPLICATE REPORT TO:

BILLING INFORMATION	
PATIENT ADDRESS	APT. #
CITY	STATE ZIP
HOME PHONE#	WORK PHONE#
BILL TO (PLEASE CIRCLE)	
<input type="checkbox"/> DOCTOR <input type="checkbox"/> PATIENT <input type="checkbox"/> CHP <input type="checkbox"/> MCR <input type="checkbox"/> MCD <input type="checkbox"/> OTHER	
PRIMARY INSURANCE NAME	

SPECIMEN INFORMATION	
DATE TAKEN: / /	
<input type="checkbox"/> CERVICAL BX @ ___ O'CLOCK	<input type="checkbox"/> VAGINAL BX
<input type="checkbox"/> ENDOCERVICAL BX	<input type="checkbox"/> VULVA BX
<input type="checkbox"/> ENDOMETRIAL BX	<input type="checkbox"/> OTHER: _____

ADDRESS	
INSURED NAME	
ID #	GROUP #

CLINICAL INFORMATION PREVIOUS SURGERY AND DIAGNOSIS	

LAB USE ONLY
<input type="checkbox"/> HISTORY DONE

FOR BARCODE LABEL ONLY
