PATHOLOGY REQUISITION
SURGICAL AND NON-GYN

PATIENT INFORMATION		Today's Date:	
Last Name:	First Name:		M.I.
STREET ADDRESS:		DOB:	SSN:
CITY: STATE: ZIP:		Gender:	
Requesting Physician Name: (Last) (First) *Signature required below*		DOB:	
Name of Insurance: ☐ Self ☐ Spouse ☐ Dependent		Member ID:	
		Send copy of insurance card with order.	

DIAGNOSIS:	Collection Date: ____/____/____ Time: _____
COPY TO:	Time in Formalin:_____

CLINICAL INFORMATION: Adequate Clinical Information is Extremely Useful for Accurate Diagnosis	
Pre-operative Diagnosis:	
Post-operative Diagnosis:	
Symptoms or Radiologic Findings:	
Preliminary/Frozen Section Diagnosis:	
Reported to:	☐ Patient ID verified

SURGICAL OR BIOPSY SITE(S):	
1.	4.
2.	5.
3.	6.

If skin biopsy, method used: ☐ Punch ☐ Shave ☐ Excisional ☐ Excisional w/margin examination

NON-GYN CYTOLOGY			**FINE NEEDLE ASPIRATION**
Collection Time: _____ Clinical History:_____ _____ _____ _____ Smears: _____ # Submitted: ____ Fluid Volume:_____mL	Urine: ☐ Void or ☐ Cath	☐ Sputum	☐ Thyroid ☐ Left or ☐ Right ☐ Breast Mass: ☐ Left or ☐ Right ☐ Breast Cyst: ☐ Left or ☐ Right ☐ Lymph Node ☐ Other_____
	Nipple Discharge: ☐ Left or ☐ Right	☐ Peritoneal Fluid	
	Pleural Fluid: ☐ Left or ☐ Right	☐ CSF	
	☐ Cyst Fluid	☐ Other:	

Physician Signature Required_____Date: _____/_____/_____

PATHOLOGY REQUISITION
SURGICAL AND NON-GYN

(Attach Patient Label Here)

White – Medical Records Yellow – Laboratory