

Facility Name

Facility Address

Facility Phone Number

Provider Full Name

Provider NPI

STAT DUPLICATE REPORT TO:

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

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:	____ / ____ / ____
BREAST BIOPSY:	
TIME SPECIMEN OBTAINED:	_____
TIME PLACED IN FORMALIN:	_____
TOTAL FIXATION TIME:	_____
<i>PLEASE SEND MAMMOGRAM REPORT WITH BIOPSY</i>	

ADDRESS	
INSURED NAME	
ID #	GROUP #

CLINICAL INFORMATION PREVIOUS SURGERY AND DIAGNOSIS	

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

FOR BARCODE LABEL ONLY
