

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 SELECT)	
<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:	____ / ____ / ____
PROSTATE BIOPSY:	
<input type="checkbox"/> PROSTATE NODULE	
<input type="checkbox"/> ELEVATED PSA : _____	
<input type="checkbox"/> ABNORMAL DRE	
<input type="checkbox"/> OTHER: _____	
<input type="checkbox"/> L lat base	<input type="checkbox"/> R lat base
<input type="checkbox"/> L lat mid	<input type="checkbox"/> R lat mid
<input type="checkbox"/> L lat apex	<input type="checkbox"/> R lat apex
<input type="checkbox"/> L base	<input type="checkbox"/> R base
<input type="checkbox"/> L mid	<input type="checkbox"/> R mid
<input type="checkbox"/> L apex	<input type="checkbox"/> R apex

ADDRESS	
INSURED NAME	
ID #	GROUP #

CLINICAL INFORMATION PREVIOUS SURGERY AND DIAGNOSIS	

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

FOR BARCODE LABEL ONLY
