



Surgical / Anatomic Pathology Requisition Form

phone 800.755.7886

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COLLECTION:		Date _____ Time _____	
Patient	Patient Last Name Legal First Name MI		
	Birthdate (MO/DAY/YR)	Age	Sex Social Security #
Physician	Physician (print) Last Name First Name	Phone #	<input type="checkbox"/> Copy to Dr. _____ <input type="checkbox"/> Call to # _____ <input type="checkbox"/> Fax to # _____
		Fax #	
	Physician Address		

Billing — Insurance (attach copy of insurance card OR complete all information below)

Insurance _____ Employer _____
Member I.D.# _____ Group # _____ SS # _____
Member Name _____ ☐ Self ☐ Spouse ☐ Child
Address _____
Secondary Ins. _____ I.D.# _____ Group # _____

Clinical History and Diagnosis (ICD-10) Code (both are required)

Sample/Site	Collection Method
Sample A	<input type="checkbox"/> Surgical excision <input type="checkbox"/> Biopsy—if Skin, specify: <input type="checkbox"/> Shave <input type="checkbox"/> Punch <input type="checkbox"/> Snip <input type="checkbox"/> Other _____
Sample B	<input type="checkbox"/> Surgical excision <input type="checkbox"/> Biopsy—if Skin, specify: <input type="checkbox"/> Shave <input type="checkbox"/> Punch <input type="checkbox"/> Snip <input type="checkbox"/> Other _____
Sample C	<input type="checkbox"/> Surgical excision <input type="checkbox"/> Biopsy—if Skin, specify: <input type="checkbox"/> Shave <input type="checkbox"/> Punch <input type="checkbox"/> Snip <input type="checkbox"/> Other _____
Sample D	<input type="checkbox"/> Surgical excision <input type="checkbox"/> Biopsy—if Skin, specify: <input type="checkbox"/> Shave <input type="checkbox"/> Punch <input type="checkbox"/> Snip <input type="checkbox"/> Other _____