PATHOLOGY REQUISITION SHEET

ETPL

S -

PATIENT NAME_____

MR# _____ **DOB** _____ **Sex** _____

Addressograph Label Here

Collection Date and Time_____ Surgeon(s)_____

Name of person filling out form_____

Primary Care Physician(s)_____

Copies of Final Report to:_____

Brief Clinical History:

Specimens Submitted:

1. _____ 7. _____

2. _____ 8. _____

3. _____ 9. _____

4. _____ 10 _____

5. _____ 11. _____

6. _____ 12. _____

Special Testing/Handling Requests_____

☐ Gross Only Specimen

☐ **Bill Insurance** ☐ **Bill Physician**

PLEASE ATTACH A COPY OF PATIENT INSURANCE INFORMATION TO THIS FORM

Patient Initials _____ Medicare patients to review and sign separate Advance Beneficiary Notice for non-covered services

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