Advanced Pathology Laboratory
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SURGICAL PATHOLOGY REQUISITION

Patient's ID Label

Submitting Facility: _____

PATIENT INFORMATION		
Name: Last First MI		Phone: ( )
☐ Male ☐ Female	DOB:	SSN:
Address:	City:	Zip:
Primary Insurance:	Policy/Group:	
Secondary Insurance:	Policy/Group:	
Subscriber Name:	Authorization number:	

SPECIMEN INFORMATION		
Date of operation:	☐ Stat	☐ Routine
Physician/Surgeon:		
Clinical diagnosis:		ICD-9:
History and pertinent clinical information:		
Prior surgery or biopsy:		
For each specimen, please include organ, site, side & procedure:		
1.		
2.		
3.		
4.		
5.		
6.		

LABORATORY USE ONLY		
S ___ - _____	Date received:	
Is specimen condition & labeling satisfactory?	☐ Yes	☐ No
Notes: _____		
CPT:	ICD-9:	