Client Information here Arial Text

PATHOLOGY/ CYTOLOGY REQUISITION

For Lab Use Only – Accession #

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX	DATE OF BIRTH	DATE COLLECTED
			M F	/ /	/ /

SOCIAL SECURITY NUMBER	PREVIOUS SURNAME/MAIDEN NAME	HOME PHONE	WORK PHONE
- -		( )	( )

ADDRESS	CITY	STATE	ZIP

INSURANCE / BILLING INFORMATION MUST BE COMPLETED or please attach front and back copies of insurance card.

BILL TO: ☐ PATIENT ☐ MEDICARE / MEDICAID* ☐ INSURANCE*

* COMPLETE SHADED BOXES BELOW

SUBSCRIBER NAME	EMPLOYER	PRIMARY INSURANCE CO	SECONDARY INSURANCE CO
SUBSCRIBER ADDRESS	EMPLOYER ADDRESS	SUBSCRIBER ID NUMBER	SUBSCRIBER ID NUMBER
CITY / STATE / ZIP	CITY / STATE / ZIP	GROUP NUMBER	GROUP NUMBER

PHYSICIAN INFORMATION

DOCTOR / PRACTITIONER SIGNATURE **DATE** / /	**SIGNS & SYMPTOMS**

ORDERING PHYSICIAN (PLEASE PRINT)	COPIES TO:	☐ *** Attention * Clinical Lab Test(s) Ordered on this specimen**	☐ Routine ☐ **STAT (Frozen Section)**

SPECIMEN(S) (Organ or Anatomic source)

CLINICAL DATA, Pre-and/or Post-Op Diagnosis

ANATOMIC SOURCE

☐ Sputum	☐ Other (Site)
☐ Effusion / Fluid Site	Additional Information:
☐ Nipple Smear (Circle) LEFT RIGHT	
☐ Tzanck Preparation Site:	Clinical Suspicion of Malignancy (Circle One) Benign 1 2 3 4 5 Malignant
☐ Fine Needle Aspiration Site:	History of Malignancy Date: Site:

88300	**88302**	**88304**	**88305**	**88307**	**88309**
88311	**88312(micro)**	**88313**	**88342-26**	**88360-26**	**88361-26**
87207	**88104**	**88172**	**88173**	**88331**	**88332**

Lawrence Memorial Hospital
Department of Pathology
325 Maine Street Lawrence, Kansas 66044
Telephone: 785-505-6170 Fax: 785-505-6227