

LOGAN HEALTH MEDICAL CENTER

PATHOLOGY REQUISITION

PATHOLOGY DEPARTMENT | Glacier Regional Pathology

310 Sunnyview Lane ♦ Kalispell, MT 59901 ♦ (406) 752-1789 ♦ (406) 751-5776 fax

Place patient label or stamp here:

****REQUIRED INFORMATION**

- **Date**
- **Cold Ischemia Time**
- **Time Placed in Formalin**
- **Document Source on Specimen Label**
- **Document Source on Requisition**

Originating Location: _____

Phone: _____

Last Name	First Name	MI	Birthdate
Street Address			Apt #
City		State	Zip
Telephone	Sex	Relationship to Patient	
	M or F	Self	Spouse Parent Other
Guarantor Name			
Street	City	State	Zip
Insurance Co.	Policy#	Group#	
Address			
Bill Physician	Bill Patient	Medicaid	Medicare
		Medicaid/Medicare#	

Submitting Physician:	Frozen Section	Call Results
Copies to:	Telephone #:	
Collection Date:	Initials:	
Date Received:	Accession Number:	

****Specimen Source – Be Specific**

When ordering tests for which Medicare reimbursement will be sought, physicians or provider shall only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes

****Date:** _____ **** Cold Ischemia Time:** _____

****Time Placed in Formalin:** _____

FOR PATHOLOGY USE ONLY:

OPERATIVE CONSULTATION / FROZEN SECTIONS:

Pertinent History – Physical Findings
Special Requests – Clinical Diagnosis

History of Cancer?

- Yes
- No
- Unknown

If Yes, Choose One:

- Carcinoma
- Sarcoma
- Melanoma
- Lymphoma
- CNS Malignancy