Patient Name: _____

DOB: _____ Age: _____ ☐ M ☐ F

SS#: _____

Address: _____

_____

Sarah Bush Lincoln
Laboratory Services
1000 Health Center Drive
P.O. Box 372
Mattoon, IL 61938
(217) 258-2247 Phone
(217)238-4584 Fax

Bill to: ☐ Account
☐ Medicare _____
☐ Medicaid _____
☐ Insurance _____

Request to bill insurance must have a copy of patient's insurance card attached.

Specimen# _____
FIN# _____
MRN _____

office use only

Submitting Physician (printed) _____ Date of Procedure: _____

Submitting Physician (signature) _____

Brief Clinical History: (Required)

Name of Procedure Performed:

Post Operative Diagnosis:

Specimen Submitted:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Diagram, Orientation, Special Requests:

SURGICAL PATHOLOGY REQUEST

P 0 0 0 1