PATHOLOGY (TISSUE SAMPLES ONLY)

BioReference LABORATORIES

PATIENT					
SOCIAL SECURITY NUMBER	Med Rec#				
NAME, LAST (OR CODE NAME) Please Print	FIRST		AGE	M/F	
STREET	APT. #	PHONE NO. ( )	DATE OF BIRTH		
CITY	STATE	ZIP	COLLECTED DATE TIME AM PM		

DOCTOR

DS/M/MED/_____
Add: post name & MD# above
2401 E., St., NW.,SA-1,L219
Washington DC 20521
202-663-1724 MD059

SURGICAL PATHOLOGY REQUEST FORM

PLEASE SUBMIT ALL PERTINENT DATA BELOW

CLINICAL DIAGNOSIS _____

SOURCE OF SPECIMEN _____

PREVIOUS SURGERY: ☐ YES ☐ NO

TYPE: _____

DATE: _____

DIAGNOSIS: _____

CLINICAL HISTORY _____

*Pathology Consults require initial Pathology report**

FOR GYN ONLY:

L M P _____

DOES PAP SMEAR ACCOMPANY THIS SPECIMEN?

☐ YES ☐ NO

FOR LAB USE ONLY:

Bx CODE _____

DX:

REMARKS:

☐ CHANGE COMPUTER Dx:

☐ FAX RESULT 9993-7 ☐ CALL RESULT 9990-3 ☐ SEND COPY 9991-1

*DOCTOR / GROUP NAME | PATIENT I.D. / ROOM NO.
ENTRIES IN THIS BOX WILL APPEAR ON REPORT

BILLING INFORMATION

☐ MEDICARE ☐ MEDICAID

PATIENT I.D. NO.

DIAGNOSIS		DX CODE
DX CODE	DX CODE	DX CODE
DX CODE	DX CODE	DX CODE

SECONDARY INSURANCE BILLING INFORMATION

INSURANCE COMPANY:

ADDRESS

CITY | STATE | ZIP

SUBSCRIBER'S NAME

ID NO.

GROUP # | SUBSCRIBER'S DATE OF BIRTH

ALL INSURANCE

RELATIONSHIP TO SUBSCRIBER
☐ CHILD ☐ SELF ☐ SPOUSE
☐ OTHER _____

NOTE: Please be sure to label each slide collected with the Patient's first and last name. Please use a pencil on frosted end of slides

INTERNAL CONTROL (LAB USE ONLY)

L-LAV	SOLOMETTE	R-RED	S-SBT	GY-GREY	BL-BLUE
GR-GREEN	YYELLOW	W-PPT	RB-ROYAL BL	STERILE CUP OTH	VIRAL CUL
C&P	BLD. CUL	FS-FROZ SPEC	SLIDE	THINPREP VIAL	FORMALIN JAR
RAND URN (CUP)	24-HOUR URINE	U-URN TUBE	TIMED URINE	BOB-BORIC/LT	OCC. BLD

vol = _____

LAB I.D. NO.