PML PATHOLOGY

Surgical Requisition

☐ STAT

***REQUIRED: COMPLETE ENTIRE INSURANCE SECTION OR ATTACH LEGIBLE FRONT/BACK COPY OF INSURANCE CARD**

PATIENT

CHART #	*DATE OF EXAM	*PHYSICIAN
	MM/DD/YYYY	

*NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX)	PHONE

*ADDRESS	CITY	STATE	ZIP

*SEX	*DATE OF BIRTH	SOCIAL SECURITY #
M ☐ F ☐	MM/DD/YYYY	

INSURANCE

*BILL: ☐ CLIENT ☐ PAT. INSURANCE ☐ PATIENT (SELF-PAY)

*SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX)	*SUBSCRIBER'S D.O.B.
	MM/DD/YYYY

*INSURANCE PLAN/PROGRAM NAME	*POLICY #	*GROUP #

*INSURANCE ADDRESS	*RELATIONSHIP TO PATIENT
	☐ Self ☐ Spouse ☐ Child ☐ Other

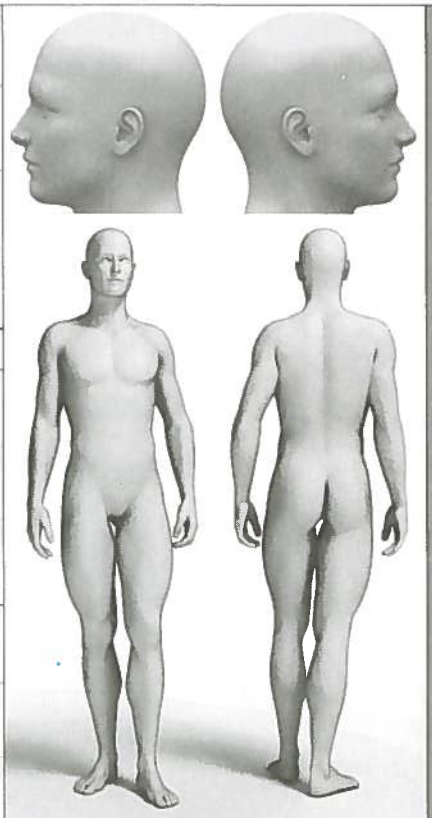
SECONDARY

*SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX)	*SUBSCRIBER'S D.O.B.
	MM/DD/YYYY

*INSURANCE PLAN/PROGRAM NAME	*POLICY #	*GROUP #

*INSURANCE ADDRESS	*RELATIONSHIP TO PATIENT
	☐ Self ☐ Spouse ☐ Child ☐ Other

SPECIMEN SITE DIAGRAMS



TISSUE/BIOPSY

*SPECIMEN SOURCE/SITE	MARGINS?	*ICD-10 DX	CLINICAL DIAGNOSIS/HISTORY
1	☐		
2	☐		
3	☐		
4	☐		
5	☐		
6	☐		

TISSUE/BIOPSY

LABELS

Patient Name: 1	Patient Name: 3	Patient Name: 5
D.O.B.:	D.O.B.:	D.O.B.:
Patient Name: 2	Patient Name: 4	Patient Name: 6
D.O.B.:	D.O.B.:	D.O.B.:

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LAB COPY