SURGICAL PATHOLOGY REQUISITION

WESTCHESTER MEDICAL CENTER

ADVANCED LABORATORY SERVICES

PATIENT DATA				INSURANCE BILLING INFORMATION	
Last Name:	First Name:			Patient Telephone Number (9 am to 5 pm) ( )	
Date of Birth: ____/____/_____	Gender: M F	MRN:	Registration No:	Insured's Name (If different from patient):	Relationship to Insured: □ Self □ Spouse □ Child □ Other
Specimen collected by:_____ Date: _____ Time_____				Patient Address:	
				City:	State: / Zip:
Attach Accession Sticker:				Medicare ID Number:	□ Regular □ Railroad
				Medicaid ID Number (Including Suffix/Person No) Physician Signature:	
				Insurance Name/Plan/HMO:	
				Policy ID Number:	Group/Book Number: / Category Number

ADEQUATE PATHOLOGY EVALUATION REQUIRES CLINICAL HISTORY

CLINICAL INFORMATION – (eg. pertinent radiologic findings, lab data, prior biopsies & surgery, etc.)
TYPE OF PROCEDURE (DIAGRAM WHERE APPROPRIATE)

ICD-10 Code:
_____

SURGICAL PROCEDURE (provide diagram where appropriate):

PRE-OPERATIVE DIAGNOSIS:

POST OPERATIVE DIAGNOSIS:

_____
PHYSICIAN'S SIGNATURE

Report Copies To:

Tissue Source & Specific Site (eg; R arm, ascending colon, cx@9:00)

Requisition Completed by (Print Legibly- Name & Phone Number)	Date:	Time: