

Physician Information:

Name _____ UPIN# _____ Phone/Fax: _____

Address: _____

Patient Information:

Name (Last, First, Middle) _____ Gender _____ DOB _____ SSN _____

Clinical Information :

I. Clinical Diagnosis Narrative: _____

II. ICD10 Code: _____

III. Clinical History _____

Specimen Information:

Collection or Surgery Date _____ Time _____ Initials _____

In Fixative (Formalin) Date _____ Time _____ Initials _____

Specimen Location	Procedure	Post-Operative Diagnosis
A. _____	_____	_____
B. _____	_____	_____
C. _____	_____	_____
D. _____	_____	_____
E. _____	_____	_____
F. _____	_____	_____
G. _____	_____	_____
H. _____	_____	_____
I. _____	_____	_____

Ordering Provider Signature _____ Date _____ Time _____

Supply Request:

Requisition Forms ☐

Formalin Bottles ☐ 20 mL ☐ 80 mL

**SURGICAL PATHOLOGY
REQUISITION**

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PATIENT LABEL

Do Not Place Below This Line.