Pacific Rim PATHOLOGY

Surgical Pathology Requisition

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www.pacificrimpathology.com

ICD-10 Diagnostic Code(s):		

Hospital/Facility: _____ Account #: _____

Pathologist/Radiologist: _____

Address: _____

Phone: _____ Fax: _____

Surgical/Case #: _____ ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Clinic/Surgery Center ☐ Other: _____

Ordering Physician: _____

Address: _____

Phone: _____ Fax: _____

C.C. Physician: _____

Patient Information: Bill to: ☐ Hospital ☐ Client ☐ Patient ☐ Insurance ☐ Medicare/Medicaid ☐ Other _____ MRN: _____

Patient's Name: _____ Social Security #: _____ Gender M F Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Relationship to Insured/Responsible Party: ☐ Self ☐ Spouse ☐ Dependent Patient's Phone #: _____

Insurance Information:

Insured/Responsible Party: _____ Social Security #: _____ Gender M F Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Member ID #: _____ Policy #: _____ Group # : _____

Insurance Co. Name: _____ Insurance Address : _____ City: _____ State: _____ Zip: _____

Renal Biopsy

☐ Native ☐ Transplant

☐ Left ☐ Right

☐ **Full Renal Panel** (LM, IF, EM)

_____

Individual Panel Components

☐ Light Microscopy (10% Zinc formalin)
☐ Tech only ☐ Global

☐ Immunofluorescence (Michel's Solution)
☐ Tech only ☐ Global

☐ Electron Microscopy (3% Glutaraldehyde)
☐ Tech only ☐ Global

Non-Gyn Cytology

	Left	Right
☐ Thyroid FNA		
Upper	☐	☐
Middle	☐	☐
Lower	☐	☐
Air Dried _____		
Alc Fixed _____		
☐ Breast FNA	☐	☐
☐ Lymph Node FNA	☐	☐
Site: _____		
☐ Pleural Fluid	☐	☐
☐ Bronchial Washing	☐	☐
☐ Bronchial Brushing	☐	☐

☐ Pelvic Wash
☐ Peritoneal Fluid
☐ Peritoneal Washing
☐ CSF
☐ Urine
☐ Catheterized
☐ Voided

Other: _____

Surgical Pathology

Biopsy/Tissue Sites

Sample 1. _____

Sample 2. _____

Sample 3. _____

Sample 4. _____

Sample 5. _____

☐ Breast Needle Biopsy
☐ Mass ☐ Lesion ☐ Calcification

Time in formalin: _____
(Required for each sample)

Consult Case:

Client Case #: _____

Slide ☐ Block ☐

Other: _____

Stained ☐ Unstained ☐

Collection Date: _____

Time: _____

Body Site: _____

Number of Samples: _____ **Collection Date:** _____ **Collection Time:** _____

Clinical History: _____

****Please include relevant clinical history, lab results and insurance information with requisition****

Name: _____	Name: _____	Name: _____	Name: _____
Specimen: _____	Specimen: _____	Specimen: _____	Specimen: _____
DOB____/____/____	DOB____/____/____	DOB____/____/____	DOB____/____/____

LAB COPY