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HISTOLOGY SPECIMEN REQUISITION

ACCESSION NUMBER	PATIENT NAME: LAST NAME FIRST	DATE OF BIRTH	AGE	SEX

REQUESTER NO: TELEPHONE NO:

SPECIMEN DATE	PERFORMING PHYSICIAN	CHART #	CALL RESULTS ☐

SEND ADDITIONAL COPY OF REPORT TO:

RESPONSIBLE PARTY DAYTIME PHONE NO.

ADDRESS

CITY STATE ZIP

BILL TO:
☐ DR./HOSP.
☐ PATIENT/INSURANCE

DO NOT WRITE IN THIS SPACE – FOR OFFICE USE ONLY

MM	DD	YY	CPT	MODIFIER		DIAGNOSIS	#	MD
			8830___	TC				BH
			8830___	26				
				TC				BH
				26				
				TC				BH
				26				

PRIMARY INSURANCE COMPANY NAME			SECONDARY INSURANCE COMPANY NAME		
INSURANCE CO. ADDRESS			INSURANCE CO. ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
INSURANCE ID NUMBER	GROUP/POLICY #		INSURANCE ID NUMBER	GROUP/POLICY #	
POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Child ☐ Other		POLICY HOLDER NAME	RELATIONSHIP TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Child ☐ Other	

CLINICAL HISTORY / IMPRESSION / DIAGNOSIS CODE: _____

CHECK FOR HELICOBACTER? ☐ YES ACCOMPANIED WITH PAP SMEAR? ☐ YES ☐ NO

SPECIMEN/SITE: PREVIOUS BIOPSY THIS SITE? YES NO

A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____