CROUSE PATHOLOGY

LABORATORY ALLIANCE
of Central New York, LLC
113 Innovation Lane • Liverpool, New York 13088
Ph: (315) 461-3008 Fax: (315) 461-3090

Histopathology Requisition

ACCOUNT NO. _____

MEDICAL RECORD NO. _____

SURGICAL NO. _____

SPECIMEN INFORMATION

DATE COLLECTED	TIME COLLECTED	COLLECTED BY
SUBMITTING PHYSICIAN		
COPY TO PHYSICIAN _____ FIRST NAME _____ LAST NAME		
PHYSICIAN'S SIGNATURE REQUIRED		

PATIENT INFORMATION

PATIENT NAME (LAST/FIRST/MI)

PATIENT I.D. NO.

SOCIAL SECURITY NO.

PHONE NO.	DATE OF BIRTH	SEX ❑ MALE ❑ FEMALE

STREET ADDRESS

CITY, STATE, ZIP

INSURANCE BILLING INFORMATION

RESPONSIBLE PARTY (SUBSCRIBER)

SUBSCRIBER SOCIAL SECURITY NO.

PATIENT RELATIONSHIP TO INSURED
❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER _____

SUBSCRIBER'S ADDRESS (CITY/STATE/ZIP)

PRIMARY INSURANCE: CO. NAME

POLICY NO.	GROUP NO.

SECONDARY INSURANCE: CO. NAME

POLICY NO.	GROUP NO.

ICD10 DX CODE(S) FOR TESTS ORDERED
(MUST BE PROVIDED)

1.	2.
3.	4.

SPECIMEN DESCRIPTION

1.
2.
3.
4.
5.
6.

CLINICAL HISTORY **(MUST BE COMPLETED) REQUIRED FOR LAB PROCESSING**

CLINICAL DIAGNOSIS (WRITTEN)

❑ Check box for FROZEN SECTION

FROZEN SECTION DX

FOR LAB USE ONLY

Batch #