ST JOSEPH'S PATHOLOGY

LABORATORY ALLIANCE
of Central New York, LLC
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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 DIAGNOSIS CODE(S)
(Numerical code or narrative diagnosis required)

1.	2.
3.	4.

SPECIMEN DESCRIPTION

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

CLINICAL HISTORY / DIAGNOSIS (WRITTEN)
(Must Be Completed - Required for Lab Processing)

FOR LAB USE ONLY

Batch #