

TISSUE EXAMINATION

R
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F
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R
R
E
D

Patient (Last, First, M) _____

Address _____

City _____ State _____ Zip _____

Phone _____ Age _____ DOB _____

Male/Female _____ SS# _____

Date Collected: _____ Time Collected: _____

Chart # _____

Ordering Physician _____

Copy To: _____

ICD - 9 Code: _____

Specimen Site/Source:

Clinical Impressions:

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

4. _____

4. _____

5. _____

5. _____

History (prev. surgery, path numbers or dates): _____

Please attach information or complete below:

Primary Insurance: _____

Secondary Insurance: _____

Claims Address: _____

Claims Address: _____

City, State, Zip _____

City, State, Zip _____

Policy & Group No: _____

Policy & Group No: _____

Employer: _____

Employer: _____

Policy Holder: _____

Policy Holder: _____

Relationship (if other than patient): _____

Relationship (if other than patient): _____

(For Pathology Use Only)

88302

88307

88313

88304

88311

88342

88305

88312

Other