SURGICAL PATHOLOGY REQUEST FORM

SIOUX FALLS, SD
MITCHELL, SD
SPENCER, IA
YANKTON, SD

Client Services: (605) 322-7212 • (800) 658-5474
Website: www.plpath.com

SEX	DATE OF BIRTH	DATE COLLECTED

SOCIAL SECURITY NO.

PRINT PATIENT NAME – FIRST, MIDDLE, LAST

STREET APT. NO.

CITY STATE ZIP

TELEPHONE NO. ( )

RESPONSIBLE PARTY & ADDRESS (if other than patient.)

CLINIC CODE

BILL TO:
☐ SUBMITTING CLINIC ☐ PATIENT / INS ☐ MEDICARE / MEDICAID ☐ INPATIENT ☐ OUTPATIENT

MEDICARE I.D. NO.

MEDICAID (WELFARE) NO.

INSURANCE COMPANY NAME, ADDRESS

INSURED'S I.D. NO.

INSURED'S GROUP NO.

CHART NUMBER

DIAGNOSIS CODE

SUBMITTING PHYSICIAN

PHYSICIAN / PROVIDER SIGNATURE

SPECIMEN(S) SUBMITTED

1) _____ Time Spec. #1 Removed: _____ Placed in Formalin: _____
2) _____ Time Spec. #2 Removed: _____ Placed in Formalin: _____
3) _____ Time Spec. #3 Removed: _____ Placed in Formalin: _____
4) _____ Time Spec. #4 Removed: _____ Placed in Formalin: _____
5) _____ Time Spec. #5 Removed: _____ Placed in Formalin: _____
6) _____ Time Spec. #6 Removed: _____ Placed in Formalin: _____
7) _____ Time Spec. #7 Removed: _____ Placed in Formalin: _____
8) _____ Time Spec. #8 Removed: _____ Placed in Formalin: _____
9) _____ Time Spec. #9 Removed: _____ Placed in Formalin: _____
10) _____ Time Spec. #10 Removed: _____ Placed in Formalin: _____

Special Requests: _____

Clinical History _____

FOR LAB USE ONLY – DO NOT WRITE OR PLACE A LABEL BELOW THIS LINE

Intraoperative Consultation _____

Frozen Section H & E Adequate? ☐ Yes ☐ No If No, Why? _____

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