UPSTATE
UNIVERSITY HOSPITAL

SURGICAL PATHOLOGY REQUISITION

ACCESSION NO.:

Name:

Sex:

Date of Birth:

Hospital #:

Location:

Date of Procedure: ____________ ☐ **Inpatient** ☐ **Outpatient**

**** FOR PATIENTS WITHOUT A UNIVERSITY HOSPITAL #, COMPLETE REVERSE SIDE ****

SPECIMENS AND ANATOMICAL SITES

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________
7. ____________
8. ____________
9. ____________
10. ____________

REASON FOR PROCEDURE:

ICD CODE(S): ____________

PREVIOUS RELEVANT DIAGNOSIS / OTHER PERTINENT INFORMATION:

SPECIFIC QUESTIONS / CONCERNS TO BE ADDRESSED:

SPECIAL REQUESTS

☐ Immunofluorescence ☐ Call results (phone number): ____________ ☐ Other: ____________

☐ Electron Microscopy ☐ Fax results (phone number): ____________ ____________

ATTENDING PHYSICIAN: ____________

Contact Phone #: ____________

SUBMITTING PHYSICIAN: ____________

Contact Phone #: ____________

Additional reports to: ____________

Patient's Name: ______________ Account #: ______________ MR#: ______________

Please complete this section or attach a copy of your Billing Information for any patient who does not have a current University Hospital Registration

PATIENT

Name: ______________

Address: ______________

Phone #: ( ) ______________ Work Phone #: ( ) ______________

Date of Birth: ______________ Soc. Sec. #: ______________

Employer Name: ______________

Employer Address: ______________

GUARANTOR

Name: ______________

Address: ______________

Phone #: ( ) ______________ Work Phone #: ( ) ______________

Employer Name: ______________

Employer Address: ______________

Insurance (1): ______________

Policy #: ______________ Group #: ______________

Address: ______________

Subscriber: ______________ Relationship: ______________

Insurance (2): ______________

Policy #: ______________ Group #: ______________

Address: ______________

Subscriber: ______________ Relationship: ______________