RED MOUNTAIN PATHOLOGY

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Homewood, AL 35209
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Lab Use Only

SURGICAL REQUISITION

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI.

DATE OF BIRTH	MRN	ROOM #

SSN	GENDER	RACE

STREET ADDRESS

CITY/STATE/ZIP

HOME PHONE # WORK PHONE #

CLIENT INFORMATION

REFERRING PHYSICIAN:
COPIES TO:

INSURANCE INFORMATION

PRIMARY INSURANCE & ADDRESS	GROUP NUMBER	CONTRACT NUMBER

RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	SUBSCRIBER NAME & DATE OF BIRTH	

SECONDARY INSURANCE & ADDRESS	GROUP NUMBER	CONTRACT NUMBER

RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	SUBSCRIBER NAME & DATE OF BIRTH	

SPECIMEN/CLINICAL INFORMATION

CLINICAL HISTORY_____

Diagnosis (Specify ICD10)

Date Collected:

Time Collected:

REQUIRED INFORMATION FOR BREAST BIOPIES ONLY

COLD ISCHEMIA TIME: ☐AM ☐PM TIME IN FORMALIN: ☐AM ☐PM

(Measured time from tissue acquisition to tissue deposition in Formalin/Saline) per College of American Pathologists (CAP) recommendation, this time should be less than 1 hour.

SPECIMEN SITE – LESION DESCRIPTION	PREOPERATIVE DIAGNOSIS
1.	
2.	
3.	
4.	

FROZEN SECTION

☐ INTRAOPERATIVE CONSULTATION	OR ROOM #:	PHONE #:

FROZEN SECTION DIAGNOSIS_____

NON-GYN CYTOLOGY TESTING

☐BAL: Source_____ ☐Urine: ☐Cath ☐Voided ☐Bladder Wash ☐UroVysion FISH ☐Other_____	☐Fluid: ☐Abdominal ☐Pleural ☐Pericardial ☐Other_____	☐FNA: Site_____ ☐Bronchial: Source_____ ☐Wash ☐Brush	☐GI: ☐Brush ☐Wash_____ ☐CSF ☐Sputum

1 **2** **3** **4**

Patient Name:_____ Patient Name:_____ Patient Name:_____ Patient Name:_____

Site 1:_____ Site 2:_____ Site 3:_____ Site 4:_____

TOP COPY - LAB • BOTTOM COPY - CLIENT