UCLA Health

PATHOLOGY OUTREACH SERVICES

# GENERAL PATHOLOGY REQUISITION

| **PATIENT NAME** (LAST) | (FIRST) | (MI) |
|---|---|---|
| GENDER ☐ M ☐ F | **DATE OF BIRTH** (MM/DD/YYYY) _____ /_____ /_____ | |
| ADDRESS | | |
| CITY | STATE / ZIP CODE | PHONE |
| **BILL TYPE:** ☐ M.D. / CLIENT ☐ PATIENT / INSURANCE<br>*ATTACH DEMOGRAPHIC SHEET WITH INSURANCE INFORMATION* | | |
| **Indicate:** Diagnosis / Signs / Symptoms in ICD-CM format in effect at Date of Service (Highest Specificity Required) | ICD-CM: / ICD-CM: / ICD-CM: / ICD-CM: | |
| COPY TO (FULL NAME / FAX NUMBER): | | |

M.D. / CLIENT NAME ACCOUNT INFORMATION

## SPECIMEN INFORMATION

| **COLLECTION DATE** | **COLLECTION TIME** |
|---|---|

Clinical Information

For Gynecologic specimens, include date of last menstrual period (LMP): _____

## OPERATIVE PROCEDURE

☐ BIOPSY ☐ PUNCH BIOPSY ☐ SHAVE BIOPSY ☐ EXCISIONAL BIOPSY ☐ OTHER

## TISSUE SPECIMEN SOURCES – FOR ROUTINE HISTOPATHOLOGY EVALUATION

| | |
|---|---|
| A | G |
| B | H |
| C | I |
| D | J |
| E | K |
| F | L |

**DELIVER SPECIMENS TO: 10833 LE CONTE AVENUE, A3-240 CHS, LOS ANGELES, CA 90095-1732**
**OR CALL CLIENT SERVICES: PHONE: 310-267-2680 FAX 310-267-2685**

(7/12/18)

Reset