Indiana University Health

IU Health Laboratory Services
350 W. 11th Street
Indianapolis, IN 46202-4108
317.491.6000 or 800.433.0740

Patient Legal Name (Last, First MI)	Date/Time of Collection
Gender (at Birth) M F	DOB
Address	SSN / MRN
City, State, Zip	Telephone Number
Print Physician's Name (F, MI, L)	Diagnosis
Physicians Signature	ICD-10 Diagnosis Codes: 1._____ 2. _____ 3. _____ 4. _____
Client:	□ BILL FACILITY □ BILL PATIENT OR INSURANCE □ SPLIT BILL: TC TO FACILITY & PC TO INSURANCE (Medicare, Medicaid, Tricare) **NOTE: For split and patient bill: Attach Face Sheet & Insurance Card**

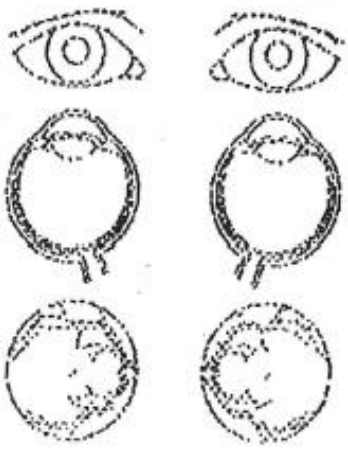
OPHTHALMIC PATHOLOGY REQUISITION

Clinical History:

Specimen Submitted: □ Wet Tissue □ Blocks □ Slides

Description:

Date of Removal:	□ OD	□ OS
Vision:	□ OD	□ OS
Pressure:	□ OD	□ OS



Imaging Findings:

Clinical Findings:

Req # 180005 Rev 03.03.2026