OSU PATHOLOGY SERVICES, LLC
OSU HISTOLOGY LAB, LLC
REQUEST FOR PATHOLOGICAL CONSULTATION

ACCOUNT NO:

APPLY PATIENT LABEL HERE TO ALL COPIES
(IF APPLICABLE)

PATIENT INFORMATION

PATIENT LAST NAME	PATIENT FIRST NAME	M. I.	SEX	DATE OF BIRTH MO/DAY/YR

PROCEDURE DATE MO/DAY/YR	MEDICAL RECORD # or SOCIAL SECURITY #	REQUESTING PHYSICIAN *SIGNATURE* and PRINTED NAME

* **CLINICAL HISTORY, PRE OP DIAGNOSIS AND ICD-9 CODES** (requesting physician's rationale for ordering the test)

BIOPSY PROCEDURE ☐ PUNCH ☐ SHAVE ☐ INCISION ☐ EXCISION ☐ CURETTE (CHECK ONE)

TISSUE SUBMITTED-LABEL CONTAINERS TO CORRESPOND WITH THE DESIGNATED ID

CONTAINER ID	TISSUE TYPE	SITE	OPERATIVE/ENDOSCOPIC FINDINGS	SPECIMEN COLLECTION TIME	START TIME IN FORMALIN
A	PLATELET ELECTRON MICROSCOPY				
B					
C					
D					
E					
F					

Pathology Consult: Correlation with Cytology material requested ☐ YES ☐ NO

PATIENT DEMOGRAPHICS

PATIENT ADDRESS		PHONE NUMBER WITH AREA CODE
CITY	STATE	ZIP CODE

BILLING INFORMATION

BILL TO: ☐ MEDICARE ☐ MEDICAID ☐ INSURANCE ☐ PATIENT ☒ ACCOUNT (CHECK ONE)

Attach a copy of the front and back of the insurance card(s) OR, complete the insurance information below.

	PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
INSURED'S NAME		
RELATIONSHIP TO PATIENT		
IDENTIFICATION NUMBER / GRP #		
NAME OF INSURANCE CARRIER		
INSURANCE ADDRESS		
INSURANCE CARRIER PHONE NUMBER		

TOP TWO COPIES MUST ACCOMPANY SPECIMEN(S)