VISTA
PATHOLOGY LABORATORY

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Place patient label here

Surgical Pathology Requisition

CLIENT INFORMATION

☐ Copy Report to:

Ordering Provider: _____

Name(s): _____

Clinic Name: _____

Address: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Name: _____ DOB: _____ ☐ Male ☐ Female

☐ Insurance ☐ Patient ☐ Medicare ☐ OHP ☐ Other: _____

Please attach billing information separately, including patient address, telephone number and insurance information.

SPECIMEN INFORMATION

Collection date: _____ Time placed into formalin: _____ If frozen section, call report to: _____
(Phone Number)

Clinical history/pre-op diagnosis: _____

ICD-10 (required): _____

Specimen source/site (if multiple, list individually below):

A) _____

B) _____

C) _____

Special handling/testing (immunofluorescence, flow cytometry, molecular testing, etc. _____