VISTA
PATHOLOGY LABORATORY
1032 E Jackson Street
Medford, OR 97504
Phone: 541.770.4559
Fax: 541.770.4511
www.vistapathology.com

Place patient label here

Surgical Pathology Requisition

CLIENT INFORMATION

Ordering Provider _____

Clinic Name _____

Address _____

_____

Phone _____ **Fax** _____

Copy Report to:

_____

_____

Collection Date _____

PATIENT INFORMATION

Name _____

DOB _____ **Gender:** ☐F ☐M ☐Unspecified

Billing Information:

☐ Insurance ☐ OHP ☐ Medicare

☐ Patient ☐ Other _____

Please attach detailed billing information separately (including patient address, phone number, and insurance information)

SPECIMEN INFORMATION

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 _____

_____

_____

_____