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Place patient label here

**Surgical Pathology Requisition**

**CLIENT INFORMATION**

Ordering Provider: \_\_\_\_\_  Copy Report to:  
 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. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_