

SERVICE REQUEST

1959 NE Pacific St, Room BB220, Seattle, WA 98195
 Phone: 206-598-6400 | UWPathology.org
 Fax: 206-598-8049 or 206-598-4928 with Accession #

Accession # (if filled, fax to 206-598-4928)

1 Patient Information	First Name	MI	Last Name
	Sex	DOB	SSN
	Patient Address		
	City	State	Zip
	Patient Phone #	Patient ID #	

2 Requesting Institution	Institution Name		
	Institution Address		
	City	State	Zip
	Person Completing Form		
	Phone	Fax	

3 Send Reports to	Requesting Physician (primary):	Phone	Fax	NPI #
	Referring Physician/Surgeon:	Phone	Fax	NPI #
	Referring Pathologist:	Phone	Fax	NPI #
	Additional reports to:	Phone	Fax	NPI #

4 Billing Information	Payment Options: <input type="checkbox"/> Patient Insurance* (If outpatient) <input type="checkbox"/> Self-Pay (No insurance) <input type="checkbox"/> Institution/Client Billing <input type="checkbox"/> Split Billing / Medicare* (Pro to Patient, Tech to Client) <small>*Medicare Billing policy does not permit tech claims on laboratory testing for hospital inpatients/outpatients. These tech charges will be billed to the requesting institution.</small>																												
	<table border="1"> <tr> <th colspan="2">Primary Insurance</th> <th colspan="2">Secondary Insurance</th> </tr> <tr> <td>ID/Policy #</td> <td>Group #</td> <td>ID/Policy #</td> <td>Group #</td> </tr> <tr> <td>Insurance Address</td> <td>Phone</td> <td>Insurance Address</td> <td>Phone</td> </tr> <tr> <td colspan="2">City/State/Zip</td> <td colspan="2">City/State/Zip</td> </tr> <tr> <td>Insured's Name</td> <td>DOB</td> <td>Relation to Pt:</td> <td>Insured's Name</td> </tr> <tr> <td></td> <td></td> <td></td> <td>DOB</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Relation to Pt:</td> </tr> </table>	Primary Insurance		Secondary Insurance		ID/Policy #	Group #	ID/Policy #	Group #	Insurance Address	Phone	Insurance Address	Phone	City/State/Zip		City/State/Zip		Insured's Name	DOB	Relation to Pt:	Insured's Name				DOB				Relation to Pt:
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5 Specimen Information						
Tissue Media	Accession Number	Block ID	Slide ID	Specimen Description	Collection Date	

6 Prognostic Testing									
FISH	Breast	GI	Lung	Solid Tumor	IHC	Breast	GI	Lung	Solid Tumor
HER2neu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HER2neu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALK/EGFR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6 Required if clinical not provided		<input type="checkbox"/> Hold for Risk Management
Previous Surgery:	Last Menstrual Period:	
Chemo/Radiation Therapy:	Other/Comments:	
Transplant (type/date):		

7 Physician Signature Required	
Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services policies found at http://pathology.washington.edu/clinical/servicerequest	
Signature:	Date:

For UW Pathology Use	
Accessioned by:	Time Stamp: