

# SERVICE REQUEST

#### For UW Pathology use

MRN:

Accession #

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

<b>2 Sending Institution</b>	Institution Name		
	Institution Address		
	City	State	Zip
	Person Completing Form		
	Phone	Fax	

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

<b>4 Billing Information</b>	<b>Payment Options:</b> <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)					
	*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.					
	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	

Note: For neuropathology services please use the form located at <https://dlmp.uw.edu/patient-care/neuropath-clinical-services>

<b>5 Specimen Information</b>	Medium:	#	Outside Accession/Case #:	Specimen Source (ex: R/L calf skin, etc):	Collect Date
	<input type="checkbox"/> Slides, <input type="checkbox"/> Blocks				
	<input type="checkbox"/> Slides, <input type="checkbox"/> Blocks				
	<input type="checkbox"/> Slides, <input type="checkbox"/> Blocks				
	<input type="checkbox"/> Slides, <input type="checkbox"/> Blocks				
	<input type="checkbox"/> Slides, <input type="checkbox"/> Blocks				
	<input type="checkbox"/> Wet Tissue				

**6 Attach:**  Report  Demographics

**Case Type:**

Slide Review (UW/HMC/FHCC Patient)

Dr: \_\_\_\_\_

Clinic: \_\_\_\_\_

Appt Date: \_\_\_\_\_

Slide Consult (Non UW/HMC/FHCC Pt.)

Breast/Gyn Pathology

Bone/Soft Tissue

Cardiac

Cytology & Cervical Biopsies

Dermatopathology

Electron Microscopy

GI Pathology

GU Pathology

Immunohistochemistry (IHC)

Immunofluorescence

Renal  Other

<b>7 Physician Signature Required</b>	
Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services policies found at <a href="https://dlmp.uw.edu/patient-care/servicerequest">https://dlmp.uw.edu/patient-care/servicerequest</a>	
Signature:	Date: