Solaris Lab
Improving lives through accurate diagnosis

REQUISITION FOR PATHOLOGY SERVICES

I. REQUESTING PHYSICIAN INFORMATION

Physician's Name: _____ Phone: _____

Preferred Report Delivery System(s): ☐ Mail ☐ Fax ☐ E-mail (PW protected)

Send Additional Report(s) To: Dr.(s) _____

_____

II. PATIENT INFORMATION

Patient's Name (Last, First MI): _____

Address: Number _____ Street: _____

City: _____ State: _____ ZIP: _____ Phone: _____

D.O.B.: ____/_____/_____ Sex: ☐ Male ☐ Female S.S.N.: _____-____-_____

Guardian's Name (If patient is minor): _____

III. CLINICAL INFORMATION

Pre-Op Dx: _____ Post-Op Dx: _____

Known Path Dx: _____ L.M.P. (Gyn cases): _____/_____/_____

Relevant Labs: _____ Relevant Meds: _____

Additional Info: _____

_____

IV. SPECIMEN A INFORMATION

Tissue: _____ Procedure: _____

Specific Location: _____ Collection: _____/_____/_____ @ ____:____

Formalin added at _____:_____ (Breast tissue only)	For additional specimens use the back of this form

Special Requests: _____

V. BILLING INFORMATION (Fill below or provide copies)

Insurance Co.: _____

Address: Number _____ Street: _____

City: _____ State: _____ ZIP: _____ Phone: _____

ID / Policy #: _____ Group # / Name: _____

Policy Holder: _____ Relationship to Patient: _____

ICD Codes:				

_____ _____

PHYSICIAN'S SIGNATURE DATE