



Sterling Pathology

National Laboratories

Surgical Pathology Requisition

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Physician Information

Dr. _____ MD UPIN# _____ Phone/Fax: _____
 Address: _____

Patient Information

Name (last,first,middle) _____ Sex _____ DOB _____ SSN _____
 Address: _____ Phone: _____

Billing Information Please attach face sheet or copy of insurance

Bill: Insurance Medicare Medicaid Patient Client
 Policy/Cert# _____

Clinical Information

I. Clinical Diagnosis _____ ICD-9 _____
 Status: New diagnosis Follow up Residual disease
 II. Prior Pathology Biopsy Surgery

Specimen Information

Collection or Surgery Date and Time _____

Specimen Location	Procedure	Post-Operative Diagnosis
A. _____	_____	_____
B. _____	_____	_____
C. _____	_____	_____
D. _____	_____	_____
E. _____	_____	_____

Authorized Signature _____ M. D.