SURGICAL PATHOLOGY REQUEST SLIP

Print Name - Press Firmly

THREE RIVERS PATHOLOGY, P.A.
2664 PATTON RD
ROSEVILLE, MN 55113

PHONE (651) 635-9700

Patient Last Name | **First Name** | **M.I.**

Guarantor Name below only if different than patient

Address (street) of patient or guarantor

City | **State** | **Zip**

Birthdate **(VERY IMPORTANT)** | **Sex**

Phone # | **Soc. Sec. #** | **Chart No.**

Dr. _____
UPIN#

Collect Date

Bill: ☐ CLINIC ☐ PATIENT/INSURANCE, HMO, PPO/ NAME & # _____

☐ Medicare No. ☐☐☐ • ☐☐ • ☐☐☐☐☐☐

☐ MN Care ☐☐☐☐☐☐☐☐

Specimen Site(s):

There is always a possibility that the requisition could become separated from the tissue specimen container.

PLEASE LABEL EACH CONTAINER WITH: PATIENT'S NAME AND SOURCE OF TISSUE

1. _____

2. _____

3. _____

Pertinent clinical history (Reason for procedure, duration, recent change, previous surgery, last menstrual period, previous PAP smear, result and number, colposcopic findings, hormone therapy, etc.)

TRP/SEND BLUE COPY; RETAIN YELLOW COPY FOR REFERENCE