

ANATOMIC PATHOLOGY CONSULT REQUISITION

PATIENT INFORMATION	BILLING INFORMATION
Patient ID #:	Contact Last Name:
Account #:	Contact First Name:
Client/Patient ID #: _____ Sample #: _____	Phone:
Patient Last Name:	Fax:
Patient First Name/ MI:	Email:
DOB: _____ Sex: _____	Office/Institution Name:
Race: _____ Ethnicity: _____	Street Address:
Social Security # _____	City: _____ State: _____ Zip: _____
Address:	<ul style="list-style-type: none"> Pre-payment is required for samples referred from outside the U.S. or Canada. For more information, please contact Nationwide Children's Hospital Client Services at 1-800-934-6575.
City: _____ State: _____ Zip: _____	
Phone: _____	
SPECIMEN INFORMATION	
Collection Date: _____ Time: _____	
Collected By (Full Name): _____	

SPECIMEN FORWARDED:

Fresh
 EM Fixative
 Formalin
 Frozen
 Other: _____

Surgical Pathology

Surgical Pathology Report(s): _____

Original Stained Slides (specify): _____

Unstained Slides (specify): _____

Paraffin Blocks (specify): _____

Other Materials (specify): _____

SERVICES REQUESTED:

Surgical Pathology

2nd opinion

Technical work only (no report generated)

Special Stains (specify)*: _____

Immunohistochemical Stains (specify)*: _____

Technical work with interpretation report

Special Stains (specify)*: _____

Immunohistochemical Stains (specify)*: _____

Cilia Biopsy
 Direct Immunofluorescence*
 Electron Microscopy

Material Requested (specify): _____

Reason for Request (specify): _____

Additional Testing (specify): _____

CLINICAL HISTORY REQUIRED:

ICD-10 CODE: _____

REQUESTING PHYSICIAN INFORMATION:

Physician Name (please print): _____

Email: _____ Fax: _____ Telephone: _____

Signature required: _____

*Write-in or include a completed Immunohistochemical/Special Stains form.