Ship To: Nationwide Children's Hospital
Attention: Anatomic Pathology
Room C1955
700 Children's Drive
Columbus, Ohio 43205
Tel: (800) 934-6575 Fax: (614) 722-5478

Anatomic Pathology Tissue Submission Requisition

TESTING REQUESTED	PATIENT INFORMATION
☐ Surgical Pathology ☐ Special Stains	Patient ID/MRN#:
☐ Immunofluorescence	Last Name:
☐ Electron Microscopy	First Name: MI:
☐ Cilia Biopsy: Motility ☐ Yes ☐ No	DOB: Sex:
☐ Additional Testing (specify):_____	Address:
If sending Renal Pathology please refer to the Renal Pathology Consult Request Form on website	City: State: Zip:
	Phone:
REFERRING PHYSICIAN INFORMATION	**BILLING INFORMATION**
Physician Name:	☐ Patient Bill (Please attach insurance demographics)
Phone: Fax:	☐ Client Bill / Institution Bill
Practice/Facility Name:	Institution/Department:
Street Address:	Street Address:
City: State: Zip:	Street Line 2:
Email:	City: State: Zip:
Signature Required:	Phone: Fax:

SAMPLE INFORMATION

Collection Date:	Collection Time: ☐ AM : ☐ PM	Collected by (Full Name):

Specimen Type (Check ALL that apply):

☐ Frozen Tissue
☐ Formalin fixed
☐ Glutaraldehyde
☐ Transport Media _____
☐ Other _____

Specimen Source (Attach additional paperwork if needed)

A.) C.) E.) G.)

B.) D.) F.) H.)

CLINICAL HISTORY – Specimens without history may delay processing

ICD-10 Code:

PROVISIONAL DIAGNOSIS