SBMF

South Bend Medical Foundation
3355 Douglas Road, South Bend, IN 46635

Surgical Pathology Requisition

Client Name: ____

✓ Physician's Last Name, First Name

[ ] ______________________ [ ] ______________________
[ ] ______________________ [ ] ______________________
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[ ] ______________________ [ ] ______________________

Collecting Department

Signature of Ordering Provider

____

(Signature must be dated, legible, and include first and last name)

Date______________________

PATIENT INFORMATION – Please print or attach patient label

Name ____
Last First MI

DOB______________ AGE ______ SEX ______ SSN ________
MO / DAY / YEAR

FIN ____________MRN __________ Inpatient ☐ outpatient ☐

BILLING

☐ PHYSICIAN / ACCOUNT
☐ PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION ATTACHED
☐ BCCP, ALPHA ID #_________

IF NO BILLING INFORMATION IS PROVIDED, AND NO BOX IS CHECKED YOUR ACCOUNT WILL BE BILLED.

PATHOLOGY USE ONLY ACCESSION #
(place label here)

OR Room Number:	**Last Name**	**First Name**	**Middle Initial**
Ordering Physician			
Additional Physician(s)			

PLEASE CHECK: ☐ **Routine** ☐ **Phone report** ☐ **STAT** ☐ **Frozen Section**

COLLECTION / CLINICAL INFORMATION

PRE-OP IMPRESSION AND CLINICAL DATA: ____

POST-OP IMPRESSION/FINDINGS: ____

Specimen Container No: _____ of _____ **Anatomic Site:**
Date of collection: __________
Time out of patient: __________ ☐ **AM** ☐ **PM**
Time placed in formalin: __________ ☐ **AM** ☐ **PM**

Specimen Container No: _____ of _____ **Anatomic Site:**
Date of collection: __________
Time out of patient: __________ ☐ **AM** ☐ **PM**
Time placed in formalin: __________ ☐ **AM** ☐ **PM**

Specimen Container No: _____ of _____ **Anatomic Site:**
Date of collection: __________
Time out of patient: __________ ☐ **AM** ☐ **PM**
Time placed in formalin: __________ ☐ **AM** ☐ **PM**

Specimen Container No: _____ of _____ **Anatomic Site:**
Date of collection: __________
Time out of patient: __________ ☐ **AM** ☐ **PM**
Time placed in formalin: __________ ☐ **AM** ☐ **PM**

Specimen Container No: _____ of _____ **Anatomic Site:**
Date of collection: __________
Time out of patient: __________ ☐ **AM** ☐ **PM**
Time placed in formalin: __________ ☐ **AM** ☐ **PM**

FROZEN SECTION **Preliminary diagnosis:**

Time specimen received______________

Time reported to surgeon______________

Stain quality acceptable? ☐ Yes ☐ No

Pathologist Signature: