



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

Surgical Pathology Requisition

Client Name: _____

✓ Physician's Last Name, First Name

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

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FROZEN SECTION **Preliminary diagnosis:** _____

Time specimen received _____
 Time reported to surgeon _____
 Stain quality acceptable? Yes No

Pathologist Signature: _____