# PATHOLOGY REQUISITION

Form# 12-5010

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|---|---|
| LOCATION/WARD: ................................................................................... | NAME OF ORDERING PRACTITIONER: |
| PATIENT NAME: ...................................................................................<br>(LAST)<br>...................................................................................<br>(FIRST) | PRINT LEGIBLY ...................................................................................<br>(LAST)<br>...................................................................................<br>(FIRST) |
| DATE OF BIRTH: ......................................................... SEX: M F<br>(DD/MM/YYYY) | Copy of report to: ............................................................................... |
| CHART #: ........................................................................................... | Address: ...............................................................................<br>............................................................................... |
| MCP#: ............................................................................................... | |
| COLLECTION DATE & TIME: ............................................ ....................hrs<br>(DD/MMM/YYYY) | Phone: ............................................................................... |
| FOR GYNECOLOGICAL SPECIMENS GIVE: | Fax: ............................................................................... |
| Date of Last Menses.........................................................................<br>(DD/MMM/YYYY) | |
| Para .................... Gravida.................... I.U.D. | |
| Hormone Therapy ....................................................................... | |

**PLEASE COMPLETE THE INFORMATION ABOVE, PRINT CLEARLY**
***Specimens may not be examined without the appropriate Demographics and Clinical Information***

SPECIMEN (S):______________________________________________________________ # OF SPECIMEN(S):__________

Time of Collection:________________________________________________(required for breast specimens)

Type of fixative: ☐ Formalin ☐ Other: ______________________________

Time placed in fixative: ________________________________

CLINICAL DIAGNOSIS/HISTORY:

PREVIOUS SURGICAL PATHOLOGY AND CYTOLOGY REPORTS:

PHYSICIAN SIGNATURE

DATE (DD/MM/YYYY)

*Revised March 24, 2016*