4path Pathology Services
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Surgical Pathology & Non-Gynecologic Cytology Test Requisition Form

Ordering Physician/Laboratory

(Required: Include the ordering physician's first & last name, NPI, practice name, complete address, phone number and fax number.)

Physician to receive additional result report:

Physician's Signature: | Date:

Patient Information (Please Print)

Name (Last, First) (Required):

In Care of:

Patient Address:

City: | State: | Zip:

Assigned Sex at Birth (Required): ☐ Female ☐ Male | Date of Birth (Required): | Patient ID#:

Phone Number:

Race: ☐ Alaska Native or American Indian ☐ Asian ☐ Black or African American ☐ Multiracial ☐ Native Hawaiian or other Pacific Islander ☐ Other race ☐ White ☐ Does not wish to disclose ☐ Not provided

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Gender Identity: ☐ Male ☐ Female ☐ Gender nonconforming ☐ Transgender male-to-female ☐ Transgender female-to-male ☐ Does not wish to disclose ☐ Not provided

Sexual Orientation: ☐ Bisexual ☐ Straight ☐ Gay or Lesbian ☐ Something else ☐ Does not wish to disclose ☐ Not provided

Billing Information (Please include a copy of the front & back of card)

Billing Type: ☐ Patient ☐ Insurance ☐ Client | Relation (Required): ☐ Self ☐ Spouse ☐ Dependant

Insured's Name (if not patient):

Insured's SS#: | Insured's DOB:

Primary Insurance Carrier: | Medicare, Medicaid or Policy ID#:

Claims Address:

Employer/Group Name: | Group#:

Pathology Tissue Specimen Information

Date Collected (Required):	Time Collected (Required):	Collected By: Ensure that two separate patient identifiers are present on each container.

ICD10 codes (required):

Surgical Pathology Specimens & Non-Gynecologic Cytology Specimens

Special Instructions:

History or Pre-op Diagnosis:

1401 ☒ Biopsy

Specimen	Specimen/Anatomic Location/Procedure
A	
B	
C	
D	
E	
F	
G	
H	
I	

For Lab use Only: Additional Clinical Information:

Testing performed on site at Medical Diagnostic Laboratories (MDL) - 08690