CLINICAL PATHOLOGY ASSOCIATES

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TISSUE REQUEST

PATIENT'S NAME - LAST, FIRST, MI			PATIENT'S SS# REQUIRED
DATE OF BIRTH	SEX	DATE COLLECTED	CHART#
PATIENT'S ADDRESS REQUIRED			PATIENT'S PHONE#
PHYSICIAN REQUIRED		HOSPITAL/CLINIC REQUIRED	PHYSICIAN'S PHONE#
TIME OF BIOPSY : am pm REQUIRED		TIME PLACED IN FORMALIN : am pm	CLINICAL HISTORY
SPECIMEN REQUIRED			

BILL TO

❑ FIRST CARE ❑ BC/BS ❑ MEDICARE ❑ MEDICAID
❑ OTHER INS. ❑ PHYSICIAN/CLINIC ❑ PATIENT

MEMBER ID/POLICY #_____

GROUP #_____ RELATION: ❑ SELF ❑ SPOUSE ❑ DEPENDENT

INSURANCE CO NAME & ADDRESS_____

INSURED'S NAME (ATTACH CARD)_____

INSURED'S EMPLOYER_____

FOR OFFICE USE ONLY

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