UR MEDICINE | Labs

ANATOMIC PATHOLOGY
REQUEST FOR OUTSIDE SLIDE REVIEW

REQUIRED (PRINT OR PATIENT LABEL)

Name(Last, First, MI)

MRN

Date of Birth

Sex:(circle) M F

Indicate primary (1) and secondary (2) insurance

__Blue Cross/Shield __Child Health Plus __MVP

__Blue Choice __Medicaid __MVPG

_Medicare Blue Choice __Medicare __Aetna

__Other _____

1. Primary Contract #: _____

Subscriber's Name: _____

Relationship to Subscriber: _____

2. Secondary Contract

Subscriber's Name: _____

Relationship to Subscriber:

Date of request:_____

Ordering provider name (print):

_____

Ordering provider signature (required):

_____

FAX or deliver request/contact our laboratories:

	PHONE	**FAX**
Surgical Pathology SMH	(585)275-3191	(585)273-3637
Surgical Pathology HH	(585)341-6802	(585)341-8267
Cytopathology	(585)275-5656	(585)276-2047
Hematopathology	(585)275-5662	(585)276-2390
Neuropathology	(585)275-3202	(585)273-1027

RELEVANT CLINICAL HISTORY (REQUIRED)
DIFFRENTIAL DIAGNOSIS/SPECIFIC QUESTIONS/LAB TESTS:

Patient's next appointment date/time_____

For Pathology office use:

DOS:_____ Visit #:_____ Assign to:_____

Billing Type: Client PT Insur

Outside Institution	# Slides	# Blocks	Outside Specimen ID#	Collection Date	Source