PATHOLOGY SERVICE REQUEST

Anatomic Pathology - Neuropathology - Histology - Cytology

Mail	Shipping/Overnight Service	Courier/Taxi
Harborview Medical Center	**HMC Pathology, 2NJ-244**	**HMC Pathology, 2NJ-244**
Pathology, Box 359791	RECEIVING DOCK (744-6315)	LOBBY RECEPTION (744-6315)
325 Ninth Avenue	908 Jefferson St	908 Jefferson St
Seattle, WA 98104	Seattle, WA 98104	Seattle, WA 98104

Phone: (206) 744-3145

Fax: (206) 744-8240

Today's Date:

www.pathology.washington.edu

- **For cytology specimens, see collection & shipping instructions.**
- **For muscle biopsies, see special protocol.**

PATIENT INFO:

PATIENT NAME		
DOB	SEX	SOCIAL SECURITY NUMBER

For HMC Pathology Office Use

HMC MRN / AAA#	HMC ACCESSION #

PLEASE BILL:

☐ INSTITUTION - Bill attn to:____________________________________

Check if you wish institution to be billed.
* If insurance information is not provided, we MUST bill the institution.
IMPORTANT - If you require split billing, see below.

☐ INSURANCE / PATIENT

Attach a copy of the patient's registation form which includes insurance carrier, group number, policy number, phone number, and patient's address.
IMPORTANT - If you require split billing, see below.

☐ SPLIT BILLING

Check here if you want institute to be billed for technical fees and patient to be billed for pro fees - supply complete information for both.

☐ ADVANCE BENEFICIARY NOTICE (ABN) has been signed.

SUBMITTED FROM:

INSTITUTION		
DEPARTMENT	PHONE #	
STREET ADDRESS		
CITY	STATE	ZIP CODE

IMPORTANT: ***Attach Pathology Report***

NEUROPATHOLOGY & HISTOLOGY MATERIALS SUBMITTED

To submit cytology materials, please use the attached Cytology Request Form*

	QUANTITY	ACCESSION #	TISSUE SOURCE
SLIDES			
BLOCKS			
	TYPE	ACCESSION #	TISSUE SOURCE
TISSUE / OTHER (Fresh, frozen, photos, x-rays, blood, etc)			

COMMENTS

- *When submitting slides, send recuts whenever possible. These will be retained.*
- *If you wish the recut slides to be returned, please check this box:* ☐

SEND REPORTS TO:

REFERRING PHYSICIAN (Last, First, MI)		NPI # (UPIN#)
ADDRESS		
CITY	STATE	ZIP CODE
PHONE	FAX	

ADDITIONAL REPORTS TO*:

PHYSICIAN NAME (Last, First, MI)		NPI # (UPIN#)
ADDRESS		
CITY	STATE	ZIP CODE
PHONE	FAX	

* If you want copies sent to other physicians, please attach another page with physician's name, NPI #, address, phone, and fax numbers.

OPTION TO RECEIVE PATHOLOGY REPORT BY FAX

Sign here to confirm that:

1) You want Pathology reports faxed to the fax number(s) above.
2) The fax machine is securely located in confidential area of your worksite.
3) The telephone line for the fax machine is designated for sending/receiving faxes only.

Signature: ____

PERSON COMPLETING FORM:

NAME
PHONE NUMBER

S:\HMC\Forms\All Path Service Request Form NJB 5-5-10.xls