

PATHOLOGY SERVICE REQUEST

Anatomic Pathology - Neuropathology - Histology - Cytology



Mail Harborview Medical Center Pathology, Box 359791 325 Ninth Avenue Seattle, WA 98104	Shipping/Overnight Service HMC Pathology, 2NJ-244 RECEIVING DOCK (744-6315) 908 Jefferson St Seattle, WA 98104	Courier/Taxi HMC Pathology, 2NJ-244 LOBBY RECEPTION (744-6315) 908 Jefferson St Seattle, WA 98104
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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 #
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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 registration 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				COMMENTS
To submit cytology materials, please use the attached Cytology Request Form*				- When submitting slides, send recuts whenever possible. These will be retained. - If you wish the recut slides to be returned, please check this box: <input type="checkbox"/>
	QUANTITY	ACCESSION #	TISSUE SOURCE	
SLIDES				
BLOCKS				
	TYPE	ACCESSION #	TISSUE SOURCE	
TISSUE / OTHER (Fresh, frozen, photos, x-rays, blood, etc)				
SEND REPORTS TO:		ADDITIONAL REPORTS TO*:		
REFERRING PHYSICIAN (Last, First, MI)		NPI # (UPIN#)		PHYSICIAN NAME (Last, First, MI)
ADDRESS		ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE
PHONE	FAX		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