PATHOLOGY REQUISITION

This form can be completed in Acrobat, printed and signed to accompany specimen

SLUCare® Physician Group

ACCESSION #

DELIVERY ADDRESSES
TO: PATHOLOGY INDEPENDENT LABORATORIES

SHIPPING ADDRESS
1212 South Spring
Schwitalla Hall, M430
Saint Louis, MO 63110

COURIER ADDRESS
3545 Vista Ave. (East of Grand)
Schwitalla Hall, Room M430
Saint Louis, MO 63104

MAIN NUMBER	HISTOPATHOLOGY	CYTOLOGY LAB	FLOW CYTOMETRY	ELECTRON MICROSCOPY
PHONE: 314-617-2800	PHONE: 314-617-2814	PHONE: 314-617-2802	PHONE: 314-617-2832	PHONE: 314-617-2854
FAX: 314-617-2786	FAX: 314-617-2793	FAX: 314-617-2787	FAX: 314-617-2792	FAX: 314-617-2786

COLLECTION ____/____/____ (Date *(MM/DD/YYYY)*) _____ (Time) ☐ A.M. ☐ P.M.

☐ **DENTAL SERVICE**

REQUIRED FIELD

SUBMITTING PHYSICIAN *(Please Print)*

SUBMITTING PHYSICIAN SIGNATURE

Clinic Name: _____

PATIENT NAME and PHONE #

PATIENT ADDRESS

CITY **STATE** **ZIP**

DATE OF BIRTH *(MM/DD/YYYY)* ☐ **MALE** ☐ **FEMALE**

PATIENT HISTORY:

OPERATIVE PROCEDURE:

OPERATIVE FINDINGS:

POST-OP DIAGNOSIS:

SPECIMEN SOURCE:

COPIES OF REPORT TO:

PHYSICIAN LAST NAME, FIRST NAME, M.I. *(Please Print)*

PHYSICIAN LAST NAME, FIRST NAME, M.I. *(Please Print)*

FLOW CYTOMETRY: **CELL MARKERS:**

NOTE: Hit tab key to enter additional text on the next line.

Pathology Request (V092121)

FOR PATHOLOGY USE ONLY

DATE RECEIVED **TIME RECEIVED** **A.M.** **P.M.** *(Circle)* **TECH INITIALS**