PATHOLOGY SERVICE REQUEST

Department of Laboratories
4800 Sand Point Way NE FB.4.510 Seattle, WA 98105
Phone: (206) 987-2103 ● Fax: (206) 987-3840
Email: PathologyAdministrationIntake@seattlechildrens.org
http://seattlechildrenslab.testcatalog.org/

SCH RQ / BILLING LABEL **(For SCH Pathology Office Use)**	SCH OUTSIDE CONSULT LABEL **(For SCH Pathology Office Use)**

IMPORTANT:
Please complete the Billing Information page (Page 2)

PATIENT INFO: (Please include a "Demographic Information/Face Sheet" with this requisition.)

Patient's Last Name	First	Middle	Birth Date **(Required)**	Legal Sex	Gender Identity

Outside Patient Number	Outside Specimen/Case Number	Send Report To
Ordering Provider		Address
Phone Number	Diagnosis/ICD Code **(Required)**	Phone/Fax

Send Additional Reports To:

Name: Fax #:

REQUIRED SPECIMEN INFORMATION:

DATE COLLECTED: _____/_____/_____ TIME COLLECTED: _____: _____ AM / PM

IMPORTANT NOTE: A copy of the Pathology Report is required. Please make sure to include the report with this requisition.

PATHOLOGY & HISTOLOGY MATERIALS SUBMITTED

	QUANTITY	ACCESSION #	TISSUE SOURCE	COMMENTS
SLIDES				**Please Note:** • When submitting slides, send recuts whenever possible. These will be retained by SCH. • If you wish the recut slides to be returned, please check this box: ☐ ○ Please provide an address, contact name, and contact phone number for the return shipment below. **Return Address for Materials:** Contact Name: Institution Name: Address: City/State/ZIP: Contact Phone: FedEx Account #:
BLOCKS				
	TYPE	**ACCESSION #**	**TISSUE SOURCE**	
TISSUE / OTHER				

ADDITIONAL NOTES:

BILLING INFORMATION

PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

BILLING NOTIFICATION: All samples will be billed to the referring institution unless complete billing and diagnosis information is provided on this form. Contact Seattle Children's Laboratory Client Services for additional assistance (206) 987-2617.

BILL TO:

☐ **Referring Institution (Preferred)** - Provide billing address or stamp institution's information.
(Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients.)

Billing Address:	Billing Contact Name:
Billing Contact Phone/Fax:	Billing Contact Email:

☐ **Primary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		Employer
Primary Care Physician		Phone Number
Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Secondary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Self Pay**- First, call Lab Client Services for pricing. Then, provide credit card information below or enclose a check with the sample.

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		
Name on Credit Card	Payment Amount	CVN
Card Number	Card Type	Expiration

Please visit our test catalog at http://seattlechildrenslab.testcatalog.org for testing information or call (206) 987-2103.

Seattle Children's®
HOSPITAL • RESEARCH • FOUNDATION

Ship to: LABORATORY
4800 Sand Point Way NE, M/S: FB.4.510
SEATTLE, WA 98105