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

www.pathology.washington.edu

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

Today's Date:

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

UW Medicine
PATHOLOGY
CYTOLOGY & MOLECULAR

SERVICE REQUEST

908 Jefferson St, **Room 2NJ244** Seattle, WA 98104
Phone: 206-744-3145 | Fax: 206-744-8240
pathology.washington.edu/clinical/women

For UW Pathology use	
MRN:	Accession #

❶ Patient Information

First Name	MI	Last Name
Sex	DOB	SSN
Patient Address		
City	State	Zip
Patient Phone #	Outside Facility Patient ID #	

❷ Requesting Institution

Institution Name		
Institution Address		
City	State	Zip
Person Completing Form		
Phone	Fax	

❸ Send Reports to

	Phone	Fax	NPI #
Requesting Physician (primary):			
Referring Physician/Surgeon:			
Referring Pathologist:			
Additional reports to:			

❹ Billing Information

Payment Options: ☐ **Patient Insurance*** (If outpatient) ☐ **Self-Pay** (No insurance) ☐ **Institution/Client Billing** ☐ **Split Billing / Medicare*** (Pro to Patient, Tech to Client)

*Medicare Billing policy does not permit tech claims on laboratory testing for hospital inpatients/outpatients. These tech charges will be billed to the requesting institution.

Primary Insurance			Secondary Insurance		
ID/Policy #	Group #		ID/Policy #	Group #	
Insurance Address	Phone		Insurance Address	Phone	
City/State/Zip			City/State/Zip		
Insured's Name	DOB	Relation to Pt:	Insured's Name	DOB	Relation to Pt:

❺ History

Last Menstrual Period:

☐ Menopausal
☐ Pregnant Now? Trimester: _____
☐ Birth Control Pills
☐ Intrauterine Device
☐ DES Exposure
☐ Estrogen Therapy
☐ Previous Irradiation
☐ Chemotherapy
☐ Clinical Cancer
☐ Previous Abnormal Cytology

❻ Pertinent Clinical Data

❼ Specimen Source:

Date Collected:

☐ Endocervical
☐ Ectocervical
☐ Vaginal Pool
☐ Vaginal Wall
☐ Penile
☐ Anal
☐ Oral
☐ Sputum
☐ Bronchial Wash
☐ Bronchial Brush
☐ Esophageal Brush
☐ Pleural fluid
☐ Ascitic Fluid
☐ Peritoneal Wash
☐ Pericardial Fluid
☐ Urine (voided)
☐ Urine (cath)
☐ Bladder Wash
☐ Cerebrospinal Fluid*
* NOT for lymphoma/leukemia evaluation
See reverse page for instructions

☐ Needle Aspirate:
Site:_______________________________
☐ Other/Collection Media:
Site:_______________________________

❽ Testing

☐ Cytology Screening / Pap
(thin prep only)
☐ High Risk HPV Screen - Reflexive
☐ High Risk HPV Screen - Regardless
☐ HPV Genotyping if HPV Screen is positive

Required:
ICD9 Codes (List all applicable codes):

❾ Physician Signature Required

Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services policies found at http://pathology.washington.edu/clinical/servicerequest

Signature:	Date: