SURGICAL PATHOLOGY REQUISITION

PATHOLOGY
SERVICES LABORATORY, P.A.
SERVING PATIENTS AND PROVIDERS SINCE 1975

1430 W C St., Russellville, AR 72801
Phone: (479) 968-6781 or (800) 874-4904
Fax: (479) 968-3074

TO BE COMPLETED BY PSL STAFF
Date Lab Received: ___________
Lab Accession #: ___________

PATIENT

First Name / Last Name / Middle Initial	DOB:	SSN:
Address:	Phone:	☐ Male ☐ Female
City, State, Zip:	Submitting Facility Patient ID#:	
Insurance Company Name & ID#: (Attach copy of insurance card)		

SPECIMEN(S)

SURGICAL PROCEDURE	SUBMITTING FACILITY	ICD-10

SPECIMEN SOURCE(S)			
1		4	
2		5	
3		6	

Additional Specimens:

Date Collected: | Time Collected:

Clinical History:

ANCILLARY TESTING

- ☐ FISH
- ☐ FROZEN (Fresh tissue only)
- ☐ FLOW (Contact lab prior to submission. Tissue must be submitted in RPMI Media.)
- ☐ PERIPHERAL BLOOD SMEAR REVIEW (Attach copy of current CBC report)
- ☐ Special Request ___________

Pre-Op Diagnosis:	Post-Op Diagnosis:
Ordering Physician Name:	Ordering Physician Signature:

Each specimen container must be labeled with the patient's FULL name, a second identifier (DOB or MR#), and source of specimen. The exact spelling of the patient's name and other identifiers should agree with the requisition. Any discrepancies will need to be resolved before we will process the specimen.