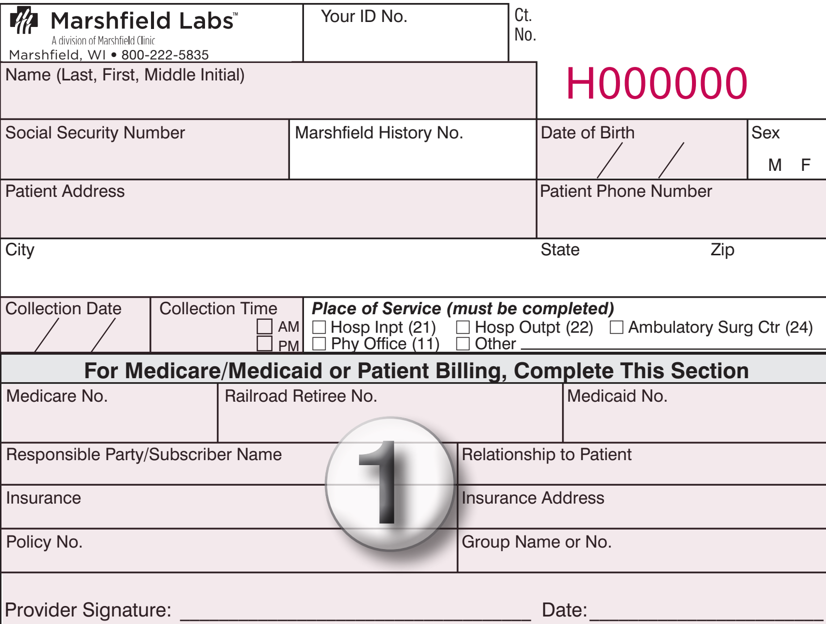

**HISTOLOGY REQUISITION**

Marshfield Labs™
A division of Marshfield Clinic
Marshfield, WI • 800-222-5835

Your ID No.

Ct. No.

H000000

Name (Last, First, Middle Initial)

| Social Security Number | Marshfield History No. | Date of Birth / / | Sex M F |
|---|---|---|---|

| Patient Address | Patient Phone Number |
|---|---|

| City | State | Zip |
|---|---|---|

| Collection Date / / | Collection Time ☐ AM ☐ PM | *Place of Service (must be completed)* ☐ Hosp Inpt (21) ☐ Hosp Outpt (22) ☐ Ambulatory Surg Ctr (24) ☐ Phy Office (11) ☐ Other |
|---|---|---|

**For Medicare/Medicaid or Patient Billing, Complete This Section**

| Medicare No. | Railroad Retiree No. | Medicaid No. |
|---|---|---|

| Responsible Party/Subscriber Name | Relationship to Patient |
|---|---|
| Insurance | Insurance Address |
| Policy No. | Group Name or No. |

1

Provider Signature: ________________________________ Date: ________________

**REASON FOR TESTING (minimum 1 ICD code required)**

**Case Level ICD code:** ____________________ ________________

I authorize Marshfield Clinic, who accepts assignment, to release any medical information necessary to process the claim and request payment benefits from the third parties listed.

________________________________ **Date:** ________________
Patient's or authorized person's signature

**Procedure - History - Differential Diagnosis**

______________________________________________
______________________________________________
______________________________________________

| | Tissue Site<br>Specimen Description<br>Special Procedures | Specimen Level ICD code (if diff. than Case Level ICD code) | Derm Path Use Only |
|---|---|---|---|
| ☐ Fresh ☐ Frozen ☐ Formalin *Fixative Type:* ____ *Cold Ischemic Time:* ____ *Time placed in Fixative:* ____ | A | | ☐ Punch ☐ Shave ☐ Excision |
| ☐ Fresh ☐ Frozen ☐ Formalin *Fixative Type:* ____ *Cold Ischemic Time:* ____ *Time placed in Fixative:* ____ | B | | ☐ Punch ☐ Shave ☐ Excision |
| ☐ Fresh ☐ Frozen ☐ Formalin *Fixative Type:* ____ *Cold Ischemic Time:* ____ *Time placed in Fixative:* ____ | C | | ☐ Punch ☐ Shave ☐ Excision |
| ☐ Fresh ☐ Frozen ☐ Formalin *Fixative Type:* ____ *Cold Ischemic Time:* ____ *Time placed in Fixative:* ____ | D | | ☐ Punch ☐ Shave ☐ Excision |

2

**Additional Specimens (include ICD codes if different than Case Level)**

______________________________________________
______________________________________________
______________________________________________

[ 00 ] FAX
GREAT CARE CLINIC
123 MAIN STREET
ANYWHERE, USA 11111
(555) 123-4567 R0000R
GRTVET ( )

[ ] 11111 DOCTOR DR MD
[ ] 22222 DOCTOR DOCTOR MD
[ ] 33333 DOCTOR DOC MD

______________________________
Physician/Provider Signature

H000000
NAME
DATE

**Histology Use Only**

S -

**Measurements - Weights - Description - FS Diagnosis**

## How To Complete a Test Requisition

1. Fill in all mandatory fields (pink shaded areas).
2. Indicate Fresh, Frozen, or Formalin; tissue site and description. For breast tissue, include Fixative Type, Cold Ischemic Time, and Time Placed in Fixative. Please note that the specimen container needs two forms of identification: patient name, birth date, and/or ID number, as well as the tissue site and description. Also, a formalin hazard sticker needs to be on the specimen container.
3. Insert top copy of requisition form into the pocket of the biohazard bag. Keep a copy for your records. Place the sample in the zip lock compartment of the biohazard bag and assure that it is completely sealed.

KEEP PINK COPY FOR YOUR RECORDS