Please complete all fields below to insure timely processing:

Patient Name

Medical History Number

Date of Birth

Gender

Person Completing Form

Phone Number

Collection Date

Collection Time

Requesting Physician's Number(s)

Location of Regional Center

History/Differential Diagnosis/Procedure

Tissue Site(s) Individually Listed

MARSHFIELD CLINIC.

Location of Patient

Hospital room no. _____ OR room no. _____
Clinic dept. _____
Clinic Ambulatory Surgery _____
Other _____

Histology Test Requisition

| Completed by | | Phone no. | **Histology Use Only** |
| Collection date | Collection time | Request dr. no. | S - |

Request dr. no. 1 | 2 | 3

Histology Use Only

S -

Measurements/Weights/Description/
FS Diagnosis

HISTORY – DIFFERENTIAL DIAGNOSIS – PROCEDURE

REASON FOR TESTING (minimum 1 ICD-9 code required)

Case level ICD-9: _____

PROCEDURE REQUESTED (check one)

☐ Tissue microscopic exam ☐ Gross only ☐ Log in only

	Tissue Site Specimen Description - Special Procedures	Specimen Level ICD-9s (if different than Case Level ICD-9)	Derm Path Use Only
☐ Fresh ☐ Frozen ☐ Formalin	A		☐ Punch ☐ Shave ☐ Excision
☐ Fresh ☐ Frozen ☐ Formalin	B		☐ Punch ☐ Shave ☐ Excision
☐ Fresh ☐ Frozen ☐ Formalin	C		☐ Punch ☐ Shave ☐ Excision
☐ Fresh ☐ Frozen ☐ Formalin	D		☐ Punch ☐ Shave ☐ Excision
☐ Fresh ☐ Frozen ☐ Formalin	E		☐ Punch ☐ Shave ☐ Excision

Spec.	Charge Codes
A	
B	
C	
D	
E	

Additional Specimens (include ICD-9s if different than Case Level)

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White: Lab   Yellow: Department   Pink: Client