LOGAN HEALTH MEDICAL CENTER

PATHOLOGY REQUISITION

PATHOLOGY DEPARTMENT | Glacier Regional Pathology

310 Sunnyview Lane ✧ Kalispell, MT 59901 ✧ (406) 752-1789 ✧ (406) 751-5776 fax

Place patient label or stamp here:

**REQUIRED INFORMATION

- **Date**
- **Cold Ischemia Time**
- **Time Placed in Formalin**
- **Document Source on Specimen Label**
- **Document Source on Requisition**

Originating Location: ______________________________

Phone: ____

Last Name	First Name	M I	Birthdate

Street Address	Apt #

City	State	Zip

Submitting Physician:	Frozen Section	Call Results
Copies to:	Telephone #:	
Collection Date:	Initials:	
Date Received:	Accession Number:	

Telephone	Sex	Relationship to Patient
	M or F	Self Spouse Parent Other

Guarantor Name

Street	City	State	Zip

Insurance Co.	Policy#	Group#

Address

Bill Physician Bill Patient Medicaid Medicare | Medicaid/Medicare#

FOR PATHOLOGY USE ONLY:

OPERATIVE CONSULTATION / FROZEN SECTIONS:

**Specimen Source – Be Specific

When ordering tests for which Medicare reimbursement will be sought, physicians or provider shall only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes

****Date:** **** Cold Ischemia Time:**

****Time Placed in Formalin:**

<u>Pertinent History</u> – Physical Findings
Special Requests – Clinical Diagnosis

History of Cancer?

- ○ Yes
- ○ No
- ○ Unknown

If Yes, Choose One:

- ☐ Carcinoma
- ☐ Lymphoma
- ☐ Sarcoma
- ☐ CNS Malignancy
- ☐ Melanoma

WHITE – Lab • YELLOW - Medical Records