



Client

**Account**

**Name:**

**Address:**

**Phone:**

Please call a client service specialist at 800.932.2943 to obtain an account # if you are not a registered Molecular Pathology Laboratory Network, Inc. *client*.

Patient

Last, First M

Male  Female

DOB \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Patient ID  Hospital #  Pathology Account # \_\_\_\_\_

Physician

**ORDERING PHYSICIAN**

\_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Billing

Client  Insurance/Patient (Please Attach Copy Insurance Info)

Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Group # \_\_\_\_\_

Insurance Address \_\_\_\_\_

Pathology

SPP - Surgical Pathology Professional Evaluation

SPC - Surgical Pathology Consultation

**Clinical History (Symptoms, size, duration, previous biopsy or treatment, calcifications, mass, etc)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Differential Diagnosis:**

\_\_\_\_\_

**Specimens**

Fixative 10% formalin  Other: \_\_\_\_\_

Time/Date in Fixative \_\_\_\_\_

A\*: \_\_\_\_\_

B\*: \_\_\_\_\_

C\*: \_\_\_\_\_

D\*: \_\_\_\_\_

E\*: \_\_\_\_\_

\*Indicate tissue type and source

**Comments**

Please complete all sections legibly to avoid reporting delays.