Mercy Lab

Surgical / Anatomic Pathology Requisition Form

phone 800.755.7886
fax 833.752.3788

COLLECTION:				
		Date _____ Time _____		
Patient	Patient Last Name Legal First Name MI			
	Birthdate *(MO/DAY/YR)*	Age	Sex	Social Security #
Physician	Physician *(print)* Last Name First Name	Phone # Fax #	☐ Copy to Dr. _____ ☐ Call to #_____ ☐ Fax to #_____	
	Physician Address			

Billing — Insurance *(attach copy of insurance card OR complete all information below)*

Insurance _____ Employer _____

Member I.D.# _____ Group #_____ SS # _____

Member Name _____ ☐ Self ☐ Spouse ☐ Child

Address _____

Secondary Ins. _____ I.D.# _____ Group # _____

Clinical History and Diagnosis (ICD-10) Code *(both are required)*

Sample/Site	Collection Method
Sample A	☐ Surgical excision ☐ Biopsy—if Skin, specify: ☐ Shave ☐ Punch ☐ Snip ☐ Other _____
Sample B	☐ Surgical excision ☐ Biopsy—if Skin, specify: ☐ Shave ☐ Punch ☐ Snip ☐ Other _____
Sample C	☐ Surgical excision ☐ Biopsy—if Skin, specify: ☐ Shave ☐ Punch ☐ Snip ☐ Other _____
Sample D	☐ Surgical excision ☐ Biopsy—if Skin, specify: ☐ Shave ☐ Punch ☐ Snip ☐ Other _____