

PATHOLOGY CONSULTATION AND SPECIAL STAIN REQUISITION

All Information Must Be Completed Before Sample Can Be Processed. Please Type or Print.

PATIENT INFORMATION

Patient Name: _____, _____, _____
Last First MI

Address: _____

Home Phone: _____

MR# _____ Date of Birth _____ / _____ / _____

Gender: Male Female

CLINICAL HISTORY

Clinical History: _____

Pre-op Dx: _____

Procedure: _____

SAMPLE/SPECIMEN INFORMATION

Specimen Type: _____

Collection Date/Time: _____

Phone # for questions: _____

FedEx account number*: _____

*If not provided, slide(s) will be returned via regular mail.

Please send unstained slide(s), paraffin block, or specimen along with request form to:

Cincinnati Children's Hospital Medical Center
Department of Pathology ML 1035
3333 Burnet Avenue
Cincinnati, OH 45229-3039

Phone: 513-636-4263

Fax: 513-636-3924

ORDERING PHYSICIAN INFORMATION

Office/ Practice/ Institution Name: _____

Ordering Physician: _____

Street Address: _____

City: _____

State: _____ Postal Code: _____ Country: _____

Phone: _____ Fax: _____

Email Address: _____

BILLING INFORMATION

REFERRING INSTITUTION

Institution: _____

Address: _____

City/State/Zip: _____

Accounts Payable Contact Name: _____

Phone: _____

Fax: _____

Email: _____

*For some tests, commercial insurance, OH, KY, or IN Medicaid can be billed.
Please attach complete demographic and insurance information.

TEST(S) REQUESTED

Pathology Slides Second Opinion/Consultation

Pathology Specimen Consultation

With interpretation

Without interpretation

Pathology Stain Request

With interpretation

Without interpretation

Please list stains: _____

PHYSICIAN SIGNATURE

Ordering Physician Signature (REQUIRED) _____ Date: _____ / _____ / _____