*First Systems & Resources, Inc.  (434) 973-4152  Fax (434) 973-6892*

UNIVERSITY of VIRGINIA HEALTH SYSTEM

# SURGICAL PATHOLOGY REQUEST

CHECK APPROPRIATE BOX FOR BILLING

☐ INSURANCE BILLING: COMPLETE SECTION 1-6 BELOW  ☐ GRANT ACCOUNT _____

☐ PATIENT BILLING (SELF PAY): COMPLETE SECTION 1-2 BELOW  ☐ WHOLESALE/ACCOUNT _____

**Lab Use Only**

Accession No. _____

| | | | | |
|---|---|---|---|---|
| PATIENT NAME (LAST, FIRST, MI) - PLEASE PRINT | LAST | FIRST | MIDDLE | SEX ☐ M ☐ F |
| PATIENT HISTORY # | DOB | PHYSICIAN NAME (LAST, FIRST) | | PHONE/PIC # |
| PHYSICIAN SIGNATURE | | RESIDENT SIGNATURE | | PHONE/PIC # |
| PATIENT LOCATION | DATE & TIME OF COLLECTION | | | |

| | | | | |
|---|---|---|---|---|
| 1. PATIENT ADDRESS (STREET OR PO BOX) | | CITY/STATE | | ZIP CODE |
| 2. PATIENT PHONE # | | PATIENT SOCIAL SECURITY # | PATIENT MARITAL STATUS ☐ S ☐ M ☐ W ☐ D | RACE ☐ W ☐ B ☐ OTHER |
| GUARANTOR NAME (LEAVE BLANK IF PATIENT IS GUARANTOR) | | GUARANTOR PHONE # | RELATIONSHIP TO PATIENT | |
| GUARANTOR ADDRESS (STREET OR PO BOX) | | CITY/STATE | | ZIP CODE |
| 3. MEDICARE: PRIMARY/SECONDARY | MEDICARE # & LETTER | 4. MEDICAID # | STATE | EFFECTIVE DATE |
| 5. OTHER INSURER ☐ PRIMARY ☐ SECONDARY | COMPANY NAME | ADDRESS | | PHONE # |
| EFFECTIVE DATE | SUBSCRIBER NAME | POLICY # | GROUP # | |

**CLINICAL HISTORY:** (must specify)

☐ Pre Op Diagnosis _____

☐ Prior Malignancy _____

☐ Chemo/Radiation Therapy _____

☐ Other _____

**ICD-9 DIAGNOSIS CODE(S)**
(Reason for sending specimen)
(Required)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

CHECK BOX if specimen is for Frozen Section

**Tissue or Slides Submitted**
(Please list each specimen)

1. ☐ **FROZEN** _____
2. ☐ **FROZEN** _____
3. ☐ **FROZEN** _____
4. ☐ **FROZEN** _____
5. ☐ **FROZEN** _____
6. ☐ **FROZEN** _____
7. ☐ **FROZEN** _____
8. ☐ **FROZEN** _____

Every effort has been made to provide this proof error free. However, since mistakes do occur, we ask that you carefully check its contents for spelling, punctuation & arrangement. Final approval becomes your responsibility when signing off...

*Thank You*

☐ Approved **WITHOUT** changes

☐ Approved **WITH** changes as marked on the proof.

Signed _____

**ADDITIONAL COPIES OF REPORT TO BE SENT TO:**

**1.** _____
PHYSICIAN NAME  ADDRESS  CITY/STATE/ZIP CODE

**2.** _____
PHYSICIAN NAME  ADDRESS  CITY/STATE/ZIP CODE

UVA048

33008  7/04