5802 Wright Drive
Loveland, CO 80538
(970) 212-0530
Fax: (970) 212-0553

ANATOMIC PATHOLOGY REQUEST

PATIENT INFORMATION

Name ______________________________ Submitting Physician ______________
LAST (Please Print) FIRST MI

Address ______________________________ Copy To ______________

______________________________ Date Of Birth ______________
CITY STATE ZIP

Sex: ☐ Female ☐ Male Patient Phone # ______________ SSN #: ______________

Insurance Card Copy REQUIRED (Front & Back)

☐ Insurance (See Attached) ☐ Medicare ______________ **Waiver on Back (ABN)**

☐ Medicaid ______________ ☐ Patient (Self-Pay)

☐ Workman's Comp. Claim# ______________ Employer Name ______________

Employer Address ______________________________

SPECIMEN INFORMATION

☐ **CYTOLOGY REQUESTED** (this box must be checked for cytology to be completed)

Collection Date: ______ / ______ / ______ Collection Time: ______________ ☐ AM ☐ PM

Diagnosis/ICD-10 ______________

SPECIMEN: A. ______________________________

B. ______________________________

C. ______________________________

D. ______________________________

E. ______________________________

F. ______________________________

G. ______________________________

H. ______________________________

I. ______________________________

J. ______________________________

History ______________________________

____

____

Physician Signature ______________________________ Date ______________