SOUTHEASTERN PATHOLOGY
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OUTPATIENT HISTOLOGY / NON-GYN CYTOLOGY REQUISITION

*Required Information - *Please Print*

Collection Date	Clinician	Additional Clinician (s)	Office Location

PATIENT

*Name (Last) _____ (First) _____ (MI) _____ PT ID # _____

*SSN _____ *Date of Birth _____ *Sex: ☐ M ☐ F

Patient Address _____ Phone _____

City _____ State _____ Zip _____

SPECIMEN(S)	REQUIRED CLINICAL HISTORY/IMPRESSION
1 _____	1 _____
2 _____	2 _____
3 _____	3 _____
4 _____	4 _____
5 _____	5 _____
6 _____	6 _____
7 _____	7 _____
8 _____	8 _____

Complete Insurance Information Below

DX codes:

PRIMARY INSURANCE

Member ID# / Policy # _____

Employer _____ Group # _____

Insured's Name _____ Relationship to Patient _____

Insured's SSN _____ Insured's DOB _____

Insurance Co. _____

Claims Address _____

City, ST Zip _____

PLEASE ATTACH COPY OF INSURANCE CARD IF POSSIBLE

SECONDARY INSURANCE

Member ID# / Policy # _____

Employer _____ Group # _____

Insured's Name _____ Relationship to Patient _____

Insured's SSN _____ Insured's DOB _____

Insurance Co. _____

Claims Address _____

City, ST Zip _____

PLEASE ATTACH COPY OF INSURANCE CARD IF POSSIBLE.

FOR SEP USE

88300 _____ CPT Level I	88311 _____ Decalcification	88305 _____ Cell Block
88302 _____ CPT Level II	88312 _____ Organism Stain	88104 _____ Smear, non GYN
88304 _____ CPT Level III	88313 _____ Other Special Stain	88112 _____ ThinPrep non-GYN
88305 _____ CPT Level IV	88342 _____ IHC Stain Manual	88173 _____ Fine Needle Aspirate Interp
88307 _____ CPT Level V	88360 _____ IHC Manual Qnt or Semiqnt	88160 _____ Cytosmear TouchPrep SI
88309 _____ CPT Level VI	88361 _____ IHC Stain VIAS	88161 _____ Cytosmear TouchPrep PSI
88321 _____ Consult on Ref Slides	85060 _____ Peripherial Smear Path Interp	3260F _____

Additional testing may be performed if determined medically necessary to render a diagnosis in the opinion of the reviewing pathologist.

CASE # _____