

PATHOLOGY SERVICE REQUEST

Anatomic Pathology - Neuropathology - Histology - Cytology



MAILING/SHIPPING ADDRESS:*

Harborview Medical Center
Box 359791, Room 2EH87
325 Ninth Avenue
Seattle, WA 98104

FRESH OR FROZEN MUSCLE BIOPSIES

See special muscle biopsy protocol

***For Cytology Specimens, please refer to Collection and Shipping Instructions.**

For HMC Pathology Office Use

Phone: (206) 744-3145
Fax: (206) 744-8240

Today's Date: _____

HMC MRN / AAA #	HMC ACCESSION #
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PATIENT INFO:		
PATIENT NAME		
DOB	SEX	SOCIAL SECURITY NUMBER

SUBMITTED FROM:		
INSTITUTION		
DEPARTMENT		
CONTACT	PHONE #	
STREET ADDRESS		
CITY	STATE	ZIP CODE

PLEASE BILL:	
<input type="checkbox"/>	INSTITUTION - Bill attn to: Check if you wish institution to be billed. * If insurance information is not provided, we MUST bill the institution. * IMPORTANT - If you require split billing, see below.
<input type="checkbox"/>	INSURANCE / PATIENT Attach a copy of the patient's registration form which includes insurance carrier, group number, policy number, phone number, and patient's address. IMPORTANT - If you require split billing, see below.
<input type="checkbox"/>	SPLIT BILLING Check here if you want institute to be billed for technical fees and patient to be billed for pro fees - supply complete information for both.
<input type="checkbox"/>	ADVANCE BENEFICIARY NOTICE (ABN) has been signed.

IMPORTANT: Attach Pathology Report!

NEUROPATHOLOGY & HISTOLOGY MATERIALS SUBMITTED:			
To submit cytology materials, please use the attached Cytology Request Form*			
	QUANTITY	ACCESSION #	TISSUE SOURCE
SLIDES			
BLOCKS			
	TYPE	ACCESSION #	TISSUE SOURCE
TISSUE / OTHER (Fresh, frozen, photos, x-rays, blood, etc)			
NOTE: - When submitting slides, send recuts whenever possible. These will be retained. - If you wish the recut slides to be returned, please check the box: <input type="checkbox"/>			

COMMENTS

SEND REPORTS TO:	
REFERRING PHYSICIAN (Last, First, MI)	NPI # (UPIN#)
ADDRESS	
CITY	STATE ZIP CODE
PHONE	FAX

ADDITIONAL REPORTS TO:	
PHYSICIAN NAME (Last, First, MI)	NPI # (UPIN#)
ADDRESS	
CITY	STATE ZIP CODE
PHONE	FAX

* If you want copies sent to other physicians, please attach another page with the physician's name, NPI #, address, phone, and fax numbers.*

OPTION TO RECEIVE PATHOLOGY REPORT BY FAX
Sign here to confirm that: 1) You want Pathology reports faxed to the fax number(s) above. 2) The fax machine is securely located in confidential area of your worksite. 3) The telephone line for the fax machine is designated for sending/receiving faxes only.
Signature: _____

PERSON COMPLETING FORM:
NAME
PHONE NUMBER