_____ Bay _____ Central _____ Lapeer _____ Flint _____ Lansing
_____ Port Huron _____ Northern _____ Oakland _____ Macomb _____ Karmanos

PATHOLOGY REQUISITION FORM

4000 S. SAGINAW ST. FLINT, MI 48507

PHONE: 810-396-5700
FAX: 810-424-2504

CLIENT/ORDERING PHYSICIAN :

Date:____________

NORTHPOINTE OBSTETRICS AND GYNECOLOGY
[ ] J.Lensmeyer JL358 [ ] J.Giles JG9125
[ ] A.Hurtubise AH393 [ ] S.Tremp ST6659
[ ] F.Drouillard FD96226 [ ] K.Fabian KF207
1206 WASHINGTON
PORT HURON, MICHIGAN 48060
810-984-3100

Phone____________________ Fax____________________

PATIENT INFORMATION

PATIENT LAST NAME	FIRST	MIDDLE	
ADDRESS			
CITY	STATE	ZIP	TELEPHONE
SSN#	DATE OF BIRTH ___/___/___	M ☐ F ☐	PATIENT I.D. #

INSURANCE INFORMATION (SEE ATTATCHED)

COLLECTION DATE / TIME	ADDITIONAL COLLECTION INFORMATION FOR BREAST BIOPSY	
___/___/___ ___:___	EXTRACTION TIME: ___:___	TIME IN FORMALIN: ___:___

SEND COPY OF REPORT TO : PHYSICIAN: ____________________
FAX # : ____________________ PHONE # : ____________________

SURGICAL PATHOLOGY ORDERS

	SPECIMEN SOURCE/SITE	SPECIMEN TYPE	PRE/POST OP DIAGNOSIS	SPECIAL REQUESTS - COMMENTS
SPECIMEN A		☐ SHAVE ☐ EXCISION ☐ PUNCH ☐ BIOPSY		
SPECIMEN B		☐ SHAVE ☐ EXCISION ☐ PUNCH ☐ BIOPSY		
SPECIMEN C		☐ SHAVE ☐ EXCISION ☐ PUNCH ☐ BIOPSY		
SPECIMEN D		☐ SHAVE ☐ EXCISION ☐ PUNCH ☐ BIOPSY		
SPECIMEN E		☐ SHAVE ☐ EXCISION ☐ PUNCH ☐ BIOPSY		
SPECIMEN F		☐ SHAVE ☐ EXCISION ☐ PUNCH ☐ BIOPSY		

* FOR ADDITONAL SPECIMENS FILL OUT SEPARATE REQUISITION AND ATTACH
CLINICAL DATA/PREVIOUS DIAGNOSIS :

75585 NAME: ____________	75585 NAME: ____________	75585 NAME: ____________
75585 NAME: ____________	75585 NAME: ____________	75585 NAME: ____________

DIAGNOSIS CODES : (ENTER ALL THAT APPLY)	1	2	3	4
5	6	7	8	9

PHYSICIAN SIGNATURE : DATE:

LAB 75585