PPMG
Peninsula Pathologists Medical Group Inc
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TISSUE EXAMINATION REQUISITION

Date of Submission

Date of Procedure (Month Day Year)

For Laboratory Use

MR#

Acct #

Patient Information

Complete information is essential for specimen evaluation.

Print legibly

Patient's Name ◯ Male ◯ Female

Address

City

State / Zip Code

Date of Birth

Social Security No.

Physician/Practitioner:

Copies to:

M.D.

M.D.

Clinical Information

ICD-9 Code (required):

Clinical History:

Procedure:

Specimen Information

Specimens submitted (include sites):

Special Handling Requests (Fresh tissue only)

◯ Frozen Section ◯ OR Consult ◯ Flow Cytometry ◯ Cytogenetics ◯ Touch Preparation (Intraoperative Cytology)

◯ Other

FAILURE TO PROVIDE MINIMAL PATIENT INFORMATION IN MARKED AREAS WILL RESULT IN DELAY OF PROCESS OR RETURN OF THE SPECIMEN.