Histopathology Request Instructions

If you have any questions, please contact your Allina Health Laboratory Account Representative for assistance.

Numbers of topics indicate the position on the Histopathology Request form diagramed on the reverse side.

1. Your site demographic information will be preprinted. Indicate ***Ordering Provider*** here.

2. If not preprinted, indicate billing preference here.

3. Complete the patient information/demographics including name, gender, date of birth and address. Billing information is essential if the work is to be billed to the patient's insurance.

4. If a copy of the report is to be sent to a location/provider other than the ordering provider, include full name, practice name, and fax number of the provider here. *Additional copies will not be sent if complete, legible, information is not provided.*

5. Provider signatures are not required, providing there is record of the order noted in the patient's medical record.

6. The exact specimen source must be documented on both the request and the specimen container. The source documented on the container must EXACTLY match the source indicated on the request form. When applicable, include right and left.

Patients with more than one specimen need only one request form. Label each specimen as A, B, C etc. and indicate source of each on the request; i.e. A) Mole, left shoulder B) Mole, right forearm C) Mole, Right Lower Back

7. The date and time that each specimen was removed from the patient and placed in formalin must be indicated here.

8. Record any clinical information here.

Example: Previous pap results, appearance of skin lesions or abnormal uterine findings such as bleeding or thickened stripe.

Histopathology Request Instructions

Allina Health LABORATORY

LAB10

ALLINA HEALTH LABORATORY
HISTOPATHOLOGY REQUEST
2800 10th Ave. S., Ste 2000, Minneapolis, MN 55407
Phone: 612-863-4678 • Fax: 612-863-4067
HOSPITAL PATHOLOGY ASSOCIATES, P.A.

2

Case Number

BILL TO (MUST CHECK ONE): ☐ CLIENT ☐ PATIENT/INSURANCE

1

DATE & TIME COLLECTED

GENDER: ☐ MALE ☐ FEMALE

BIRTH DATE (MM-DD-YYYY)
- -

3

PATIENT NAME: LAST, FIRST M.I

CHART #

PATIENT ADDRESS : STREET and C

STATE ZIP

PATIENT PHONE
( )

INSURANCE

☐ MEDICARE PRIMARY ☐ MEDICARE SECONDARY

MEDICARE

MEDICAL ASSISTANCE NUMBER

STATE

INSURANCE CO. NAME

RELATIONSHIP OF PATIENT TO INSURED
☐ SELF ☐ SPOUSE ☐ DEPEND. ☐ OTHER

POLICY HOLDER'S NAME

POLICY HOLDER DATE OF BIRTH (IF NOT PATIENT)
- -

SUBSCRIBER ID #

GROUP #

Additional copy of pathology report should be sent to:

Provider : _____
First Name MI Last N

4

Practice name: _____

Fax #: _____

Reports cannot be faxed if complete information is not provided

Pathology Testing will always be ordered/performed on appropriate specimens for all samples submitted with this requisition.

PROVIDER SIGNATURE:

5

6292 and 12482

Specimen	Source (specific)	Date excised	Time excised	Date in formalin	Time in formalin
A					
B					
C					
D					
E					
F					
G					
H					
I					

6

7

Clinical information **(reason for biopsy)** and previous tissue or cytology diagnosis:

8

Affix RQ Label Here

HISTO (7/17) Number of Containers _____ ☐ Ordered by (A#) _____