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Please write your address below:

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Pathology Laboratory Associates

4142 S Mingo Rd. Tulsa, OK 74146 (918) 417-6400
WWW.PLAPATH.COM (833) PLA-PATH

☐ CALL
☐ FAX

☐ STAT

Completed by: ___________________________

PATIENT INFORMATION Please Provide All Information below **(Name on Requisition MUST Match Name on Specimen EXACTLY!)**

LAST NAME (Please Print Legibly) FIRST MIDDLE	PATIENT ID#	SEX M☐ F☐	DATE OF BIRTH [MM / DD / YYYY]

PATIENT ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE

COLLECTION DATE:	TIME: ☐ A.M. ☐ P.M.	PATIENT MRN.	NAME OF GUARANTOR:

FOR LAB USE ONLY
LAB ID:

RCV'D TIME/DATE:

SPECIMENS RCV'D

- ☐ Tissue
- ☐ Nail(s)
- ☐ Hair
- ☐ Scrapings
- ☐ Fluid
- ☐ Sterile container, no additive ____
- ☐ Sterile container with moistened gauze ____
- ☐ Sterile container with saline ____
- ☐ 10% buffered formalin container ____
- ☐ DIF: Michel's media or Zeus solution ____
- ☐ ExCell Plus™ container ____
- ☐ eSwab
- ☐ RPMI Preservative ____

REQUESTING PHYSICIAN [Last Name, First Name]

Provider signature: ___________________________

BILLING INFORMATION (Required)

BILL: ☐ **CLIENT/ OFFICE** ☐ **PATIENT/ INSURANCE**

Complete or provide a photo copy of the patient's insurance card(s)

PRIMARY INSURANCE CARRIER	2nd - INSURANCE CARRIER
POLICY/ MEMBER/ MEDICARE NUMBER	2nd - POLICY/ MEMBER/ MEDICARE NUMBER
GROUP NUMBER/ PERSONAL CODE	2nd - GROUP NUMBER/ PERSONAL CODE
POLICY HOLDER	2nd - POLICY HOLDER
EMPLOYER	2nd - EMPLOYER

CONSULTING COPY TO PHYSICIAN(s) [Last Name, First Name]
(COMPLETE MAILING ADDRESS or FAX NUMBER is REQUIRED to SEND a CONSULT REPORT)

Previous Pathology Case#___________________________

[ ]Histology Pathology Exam 8090000

A. Specimen/Source___________________________
ICD 10 Code/Clinical Impression___________________________

B. Specimen/Source___________________________
ICD 10 Code/ Clinical Impression___________________________

C. Specimen/Source___________________________
ICD 10 Code/Clinical Impression___________________________

D. Specimen/Source___________________________
ICD 10 Code/Clinical Impression___________________________

Specimen Information

Clinical History:___________________________

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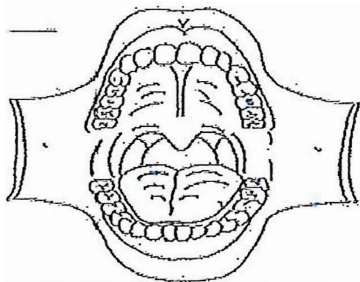
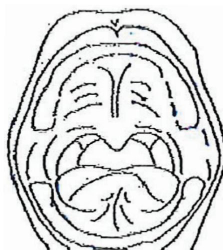
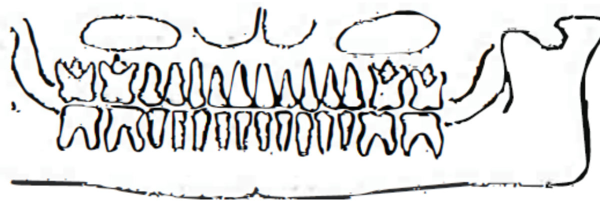
Location:___________________________ Specimen was: Excision:____ Incision______

Enclosed: X-Rays Yes__ No___Photos Yes_____ No_____ Curettage__________

Clinical Diagnosis:___________________________







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Physician authorizes PLA to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient as directed.