CHI Mercy Health Mercy Medical Center

2700 Stewart Parkway Roseburg, OR 97471

PATHOLOGY

PATIENT NAME: ______________________________ PHYSICIAN: ______________________________
LAST FIRST

DATE: __________ DOB: __________ AGE: __________ ROOM: __________ MEDICAL RECORDS NO.: __________

SITE OF SPECIMEN OR FLUID: ______________________________

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CLINICAL DIAGNOSIS: ______________________________

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PLEASE ENCLOSE OUTPATIENT BILLING INFORMATION . . . THANK YOU.

PART 1 - TRANSCRIPTION PART 2 - PATHOLOGIST PART 3 - OFFICE

7060115 (3/16)