FOR LAB USE ONLY:

ACCT.# _____

**Scheduling:**
Phone: (850) 416-6800, Option
Hours: Mon - Fri, 7:00a - 5:30p
Lab Order **Fax Server:** (850) 416-7337

Ascension Sacred Heart Pensacola

# Pathology Requisition

**ALL HIGHLIGHTED AREAS ARE REQUIRED TO BE A VALID ORDER**

**AGENCY OR FACILITY:**

FACILITY NAME: _____

FACILITY ADDRESS: _____

_____

DIRECT PHONE #: (____)____-_____

**SPECIMEN**

Collected By (First & Last Name): _____

Date Collected: _____ Time Collected: _____ AM / PM

**ORDER DATE:** ____/____/____

**PATIENT'S FULL NAME:** _____
Last First MI

**DOB:** ____/____/____ SSN: ____ - ____ - ____

PHONE #: (____) ____ - ____ SEX: M F

ADDRESS: _____

**Insurance Carrier:** _____

**Policy #:** _____ **Group #:** _____

**Guarantor:** ☐ Self ☐ Other: _____
Last First MI

**DOB:** ___/___/___ **Relationship:** _____ Phone #: (___)___-____

Insurance Authorization #: _____ Exp. Date: ____/___/____

**PROVIDER'S FULL NAME:** _____
Last First MI

**PROVIDER'S SIGNATURE:** _____

Copy to Provider: _____
Last First MI

Provider's Phone #: (____)____-_____

| ☐ **Fax Report To:** | ☐ **Critical Report:** |
|---|---|
| Fax #: | Phone #: |

☐ *Ascension Sacred Heart Pensacola –*
5151 N Ninth Avenue
Pensacola, FL 32504
Phone: (850) 416-7000

☐ *Ascension Sacred Heart Emerald Coast –*
7800 US-98
Miramar Beach, FL 32550
Phone: (850) 278-3000

☐ *Ascension Sacred Heart Bay –*
615 N Bonita Ave A
Panama City, FL 32401
Phone: (850) 769-1511

☐ *Ascension Sacred Heart Gulf –*
3801 US-98
Port St. Joe, FL 32456
Phone: (850) 229-5600

**When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes. In the event that Ascension Sacred Heart Laboratory cannot perform a test ordered, a Reference Lab will be utilized. The Reference Lab will bill directly for tests performed.**

**DIAGNOSIS CODE** _____

## ☐ Pathology Tissue Request

Specimen Priority: ☐ Routine ☐ STAT

Specimen Collection Date & Time: _____

Pre Op: _____

Post Op: _____

### ☐ Pathology Placenta Request

EDC by Dates/Exam: _____

Birthweight: _____

Infant APGARS: _____

Delivery Date: _____

Reason for Exam: _____

### ☐ Pathology Breast Request

Ischemic Time: _____

Time in Formalin: _____

Specimens Source:

A: _____

B: _____

C: _____

D: _____

E: _____

F: _____

G: _____

H: _____

I: _____

J: _____

K: _____

L: _____

**DIAGNOSIS CODE** _____

## ☐ Pathology Gyn Request

Specimen Collection Date & Time: _____

Clinical History/Dx: _____

LMP: _____ MM _____ DD _____ YYYY

Specimen Source: ☐ Cervical ☐ Endocervical ☐ Vaginal

Type: ☐ Conventional ☐ Liquid Prep with Reflex HPV ☐ Liquid Prep ☐ Liquid Prep with HPV

Hormones: ☐ YES ☐ No

Postpartum: ☐ YES ☐ No

Hysterectomy: ☐ YES ☐ No

Pregnant: ☐ YES ☐ No

Postmenopausal: ☐ YES ☐ No

## ☐ Pathology Non-Gyn Request

Specimen Collection Date & Time:

Clinical History/Dx:

Specimen Type:

- Ascitic Fluid ☐
- Aspirate, Site: _____ ☐
- Bronchial Alveolar Lavage ☐
- Breast Cyst Fluid/Nipple Discharge ☐
- Bronchial Brushing ☐
- Bronchial Washing ☐
- Cerebrospinal Fluid ☐
- FNA, Site: _____ ☐
- Smear, Site: _____ ☐
- Sputum ☐
- Urine ☐
- Urine for Ploidy ☐
- Washing, Site: _____ ☐
- Other: _____ ☐

**CLIA # 10D0271186**

Total Tests Ordered: ☐

FOR LAB USE ONLY:

ACCT.# _____

**Scheduling:**
Phone: (850) 416-6800, Option
Hours: Mon - Fri, 7:00a - 5:30p
Lab Order **Fax Server:** (850) 416-7337

Ascension Sacred Heart Pensacola

# Pathology Requisition

**ALL HIGHLIGHTED AREAS ARE REQUIRED TO BE A VALID ORDER**

**AGENCY OR FACILITY:**

FACILITY NAME: _____

FACILITY ADDRESS: _____

_____

DIRECT PHONE #: (____)____-_____

**SPECIMEN**

Collected By (First & Last Name): _____

Date Collected: _____ Time Collected: _____ AM / PM

**ORDER DATE:** ____/____/____

**PATIENT'S FULL NAME:** _____
Last First MI

**DOB:** ____/____/____ SSN: ____ - ____ - ____

PHONE #: (____) ____ - ____ SEX: M F

ADDRESS: _____

**Insurance Carrier:** _____

**Policy #:** _____ **Group #:** _____

**Guarantor:** ☐ Self ☐ Other: _____
Last First MI

**DOB:** ___/___/___ **Relationship:** _____ Phone #: (___)___-____

Insurance Authorization #: _____ Exp. Date: ____/___/____

**PROVIDER'S FULL NAME:** _____
Last First MI

**PROVIDER'S SIGNATURE:** _____

Copy to Provider: _____
Last First MI

Provider's Phone #: (____)____-_____

| ☐ **Fax Report To:** | ☐ **Critical Report:** |
|---|---|
| Fax #: | Phone #: |

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**DIAGNOSIS CODE** _____

## ☐ Pathology Tissue Request

Specimen Priority: ☐ Routine ☐ STAT

Specimen Collection Date & Time: _____

Pre Op: _____

Post Op: _____

### ☐ Pathology Placenta Request

EDC by Dates/Exam: _____

Birthweight: _____

Infant APGARS: _____

Delivery Date: _____

Reason for Exam: _____

### ☐ Pathology Breast Request

Ischemic Time: _____

Time in Formalin: _____

Specimens Source:

A: _____

B: _____

C: _____

D: _____

E: _____

F: _____

G: _____

H: _____

I: _____

J: _____

K: _____

L: _____

**DIAGNOSIS CODE** _____

## ☐ Pathology Gyn Request

Specimen Collection Date & Time: _____

Clinical History/Dx: _____

LMP: _____ MM _____ DD _____ YYYY

Specimen Source: ☐ Cervical ☐ Endocervical ☐ Vaginal

Type: ☐ Conventional ☐ Liquid Prep with Reflex HPV ☐ Liquid Prep ☐ Liquid Prep with HPV

Hormones: ☐ YES ☐ No

Postpartum: ☐ YES ☐ No

Hysterectomy: ☐ YES ☐ No

Pregnant: ☐ YES ☐ No

Postmenopausal: ☐ YES ☐ No

## ☐ Pathology Non-Gyn Request

Specimen Collection Date & Time:

Clinical History/Dx:

Specimen Type:

- Ascitic Fluid ☐
- Aspirate, Site: _____ ☐
- Bronchial Alveolar Lavage ☐
- Breast Cyst Fluid/Nipple Discharge ☐
- Bronchial Brushing ☐
- Bronchial Washing ☐
- Cerebrospinal Fluid ☐
- FNA, Site: _____ ☐
- Smear, Site: _____ ☐
- Sputum ☐
- Urine ☐
- Urine for Ploidy ☐
- Washing, Site: _____ ☐
- Other: _____ ☐

**CLIA # 10D0271186**

Total Tests Ordered: ☐