UW Medicine
PATHOLOGY
IHC & MOLECULAR

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SERVICE REQUEST

Clear Form

For UW Pathology use	
MRN:	Accession #

❶ Patient Information

First Name	MI	Last Name	
Sex	DOB	SSN	
Patient Address			
City	State	Zip	
Patient Phone #	Outside Facility Patient ID #		

❷ Requesting Institution

Institution Name		
Institution Address		
City	State	Zip
Person Completing Form		
Phone	Fax	

❸ Send Reports to

	Phone	Fax	NPI #
Requesting Physician (primary):			
Referring Physician/Surgeon:			
Referring Pathologist:			
Additional reports to:			

❹ Billing Information

Payment Options: ☐ Patient Insurance* (If outpatient) ☐ Self-Pay (No insurance) ☐ Institution/Client Billing ☐ Split Billing / Medicare* (Pro to Patient, Tech to Client)

*Medicare Billing policy does not permit tech claims on laboratory testing for hospital inpatients/outpatients. These tech charges will be billed to the requesting institution.

Primary Insurance			Secondary Insurance		
ID/Policy #	Group #		ID/Policy #	Group #	
Insurance Address	Phone		Insurance Address	Phone	
City/State/Zip			City/State/Zip		
Insured's Name	DOB	Relation to Pt:	Insured's Name	DOB	Relation to Pt:

❺ Specimen Information

Tissue Media	Accession Number	Block ID	Slide ID	Specimen Description	Collection Date

❻ Prognostic Testing

FISH	Breast	GI	Lung	Solid Tumor
HER2neu	☐	☐	☐	☐
ALK/EGFR	☐	☐	☐	☐

IHC	Breast	GI	Lung	Solid Tumor
HER2neu	☐	☐	☐	☐
MSI	☐	☐	☐	☐

❻ Required if clinical not provided

☐ **Hold for Risk Management**

Previous Surgery:	Last Menstrual Period:
Chemo/Radiation Therapy:	Other/Comments:
Transplant (type/date):	

❼ Physician Signature Required

Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services policies found at http://pathology.washington.edu/clinical/servicerequest

Signature:	Date:

For UW Pathology Use	
Accessioned by:	**Time Stamp:**