

HEMATOPATHOLOGY SPECIMEN REQUISITION FORM

Pathology Accession (For Laboratory Use Only)

(BONE MARROW, PERIPHERAL BLOOD, LYMPH NODES, OTHER)

3301 C Street , #200E, Sacramento, CA 95816 **Customer Service and Courier Pickup** 916-446-0424; Toll-free 800-464-0424 FAX 916-446-9330

Required Fields - Please fill out all info	mation in box. Thank you.				
Patient Name: Last, First				Date Bi	opsy Taken
Patient Address	Ci	ity	Zip Code	Telepho	ne Number
Date of Birth	Age	Sex	Social Security	Number	
SPECIMEN INFORMATION (Please indi	cate type of specimen, number of t	rubes / containers, and	d body site)		
Collection Date:	Collection Time:	ΔΜ / Ι	PM ICD-9 Code(s):	,	,
Blood: Green Top Purple Top		AM / I	m icb-7 code(s):	/	
☐ Bone Marrow: Green Top Purple		Clot Smar	ars Touch Pre	ns	
☐ Lymph Node: Body Site(s)				P*	
☐ Other Tissue: Body Site(s)					
CLINICAL DATA (Please provide copy of re					
		5)			
Diagnosis under consideration / address what					
Prior Therapy No Yes					
1101 11101 2110 21101					
CLINICAL LUCTORY					
CLINICAL HISTORY (Please attach recent su	mmary of patient history or notes f	rom recent clinical visi	t / hospitalization)		
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