

CLIENT NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_  
 TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_  
 CONTACT NAME: \_\_\_\_\_



**UMass Memorial Medical Center**  
 Hospital Laboratories  
 365 Plantation Street  
 Worcester, MA. 01605  
 508-334-2863

## Anatomic Pathology Requisition

PATIENT LAST NAME	FIRST NAME	MI	SEX	SOC. SEC. #	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP	HOME PHONE	
REQUESTING PHYSICIAN	UPIN #	CLIENT MEDICAL RECORD #			
COLLECTION DATE	SPECIMEN SOURCE				

**Bill to:**  Client  Patient/Insurance (for outpatient services only - fill out shaded area or attach information)

RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT (LAST, FIRST, MI)			INSURANCE COMPANY NAME		
ADDRESS			ADDRESS		
CITY / TOWN		STATE	ZIP	CITY / TOWN	
STATE		ZIP	STATE		ZIP
MEDICARE #	MEDICAID #	PCC#	GROUP	POLICY #	

CLINICAL DIAGNOSIS AND ICD-9 CODE ARE REQUIRED PRIOR TO INTERPRETATION:

ICD-9 CODE:
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<b>SURGICAL PATHOLOGY</b> 508-793-6100	<b>GYNECOLOGICAL CYTOLOGY</b> 508-793-6120
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- Formalin fixed tissue
- Special studies (please call 508-793-6100 for arrangements)
  - Renal Biopsy
  - Muscle / Nerve Biopsy
  - Electron Microscopy
  - Immunofluorescence
  - DNA Ploidy
- Consults: Please send a copy of the pathology report along with the glass slides and/or paraffin block. Samples will be returned via UPS.

- Check one from each column
- |   |   |
|---|---|
| <input type="checkbox"/> ThinPrep Pap test with HPV testing if ASCUS<br><input type="checkbox"/> ThinPrep Pap test and HPV testing<br><input type="checkbox"/> Pap smear / ThinPrep Pap test only<br><input type="checkbox"/> HPV test only (requires ThinPrep collection vial) | <input type="checkbox"/> Screening<br><input type="checkbox"/> Diagnostic |
|---|---|

<b>Clinical History</b> <input type="checkbox"/> regular cycle <input type="checkbox"/> hormonal Rx. <input type="checkbox"/> pregnant <input type="checkbox"/> previous abn. <input type="checkbox"/> post partum <input type="checkbox"/> IUD <input type="checkbox"/> post menop. <input type="checkbox"/> pelvic rad. <input type="checkbox"/> s/p hysterect. <input type="checkbox"/> chemotherapy	<b>Source:</b> <input type="checkbox"/> vaginal <input type="checkbox"/> cervical <input type="checkbox"/> endocervical LMP ___/___/___
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<b>HEMATOPATHOLOGY</b> 508-793-6230	<b>NON-GYNECOLOGICAL CYTOLOGY</b> 508-793-6120
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- Lymphoma / Leukemia Flow Cytometry & Immunohistochemistry
- Anti-neutrophil Antibody
- CD4/CD8 Enumeration (please specify counts if available)
- PNH
- Other \_\_\_\_\_

<u>Specimen Source</u>	right	left	
<input type="checkbox"/> BAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CSF
<input type="checkbox"/> Bronch Brush	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Voided Urine
<input type="checkbox"/> Bronch Wash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cath. Urine
<input type="checkbox"/> Pleural Fluid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bladder Wash
<input type="checkbox"/> Peritoneal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sputum
			<input type="checkbox"/> other _____

<b>MOLECULAR ONCOLOGY</b> 508-793-6240
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- DNA/RNA analysis by PCR, Southern Blot or In Situ Hybridization
- |  |   |
|--|---|
| <input type="checkbox"/> B Cell Clonality            | <input type="checkbox"/> bcl-2 t(14;18)       |
| <input type="checkbox"/> T Cell Clonality            | <input type="checkbox"/> MYCN amplification   |
| <input type="checkbox"/> bcr/abl t(9;22)quantitative | <input type="checkbox"/> Leukemia - Multiplex |
| <input type="checkbox"/> 1p19q chromosome deletion   | <input type="checkbox"/> pml/rara t(15;17)    |
| <input type="checkbox"/> Her2/Neu                    | <input type="checkbox"/> UroVysion            |
| <input type="checkbox"/> EBV analysis                |   |
| <input type="checkbox"/> Other: _____                |   |

<u>History</u>	yes	no	<input type="checkbox"/> FNA
Chemo	<input type="checkbox"/>	<input type="checkbox"/>	Site: _____
Radiation	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	