UnityPoint Health
Finley Hospital

350 N. Grandview Ave.
Dubuque, IA 52001
(563) 589-2431

Accession #:

SURGICAL PATHOLOGY REQUISITION

Ordering Physician: ____________________

Copy to: ____________________

Patient Information **(Please print or use computer generated label)**

Last Name	First Name	MI	Birthdate	Age	Gender

Patient Address:

Patient ID or Medical Record #:

Social Security Number:

Patient Phone Number:

Bill To: ☐ Patient ☐ Insurance ☐ Account ☐ Other

Copy Insurance Card (front and back) and attach OR complete the following:

Primary Insurance ____________ **Policy #** ____________ **Group #** ____________

Subscriber Name ____________ Relationship to Patient: ☐Self ☐Spouse ☐Other

Insurance Address ____________

Secondary Insurance ____________ **Policy #** ____________ **Group #** ____________

Subscriber Name ____________ Relationship to Patient: ☐Self ☐Spouse ☐Other

Insurance Address ____________

Collection Date: ______/______/______ **Collection Time:** ____________

Specimen Source: A.____________ B.____________

C.____________ D.____________

History/Clinical Diagnosis and/or ICD Code:

____

____

____

If stereotactic breast biopsy; Calcifications (circle one): Present Absent

ICD/Diagnostic Codes: A________ B.________ C________ D ________
(Required, if not given above)