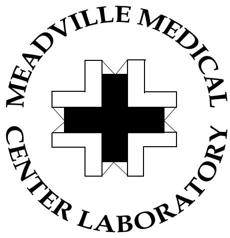

PATHOLOGY/CYTOLOGY *(Non-Gyn)*

751 Liberty Street, Meadville, PA 16335
Phone (814) 333-5517

Histo spec #

Date Collected___/___/___

Physician/NPP signature ______________________________

Ordering Provider ______________________________ PCP______________________________

Copy of Reports to______________________________

Pre-op diagnosis/ICD-10 (*for insurance purposes- be specific*) ______________________________

____

Post-op diagnosis/ICD-10______________________________

____

Pertinent history/previous surgery ______________________________

____

Specimen(s) / Site ______________________________

____

____

PATIENT BILLING INFORMATION

Patient Name *Last* *First* *MI*	Date of Birth
Patient Account Number	❐ **M** ❐ **F**
Address	City /State / Zip
Employer Name	
Address	
Insurance Company	Policy #
Insured Name	Group #

Form # 40230 (April 2021) Lab use – White copy Hospital Registration – Yellow copy Physician office – Pink Copy