LINCOLN DIAGNOSTICS LLC.
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Diagnosis@LincolnLab.us

Specimen #

For Lab Use ONLY

SURGICAL PATHOLOGY REQUISITION

CLIENT INFORMATION

Requesting Physician _____

PATIENT INFORMATION

Last Name | First Name | M.I.

Date of Birth *(Required)* _____/_____/_____ | Gender *(Req.)* ☐ ☐ | Date Specimen Collected *(Req.)* _____/_____/_____

Street Address | Apt. #

City | State | Zip

Social Security # | Telephone #

BILLING INFORMATION

PLEASE ATTACH A COPY OF THE INSURANCE CARD (FRONT AND BACK), OR FILL IN THE NECESSARY INFORMATION BELOW, THANK YOU

☐ **Check here if self-pay** (If checked, please, attach the acknowledgment form)

☐ **Secondary insurance exists.** If checked, please include a photocopy of both carriers and clearly indicate primary and secondary.

Insurance Carrier: | Address | City | State | Zip

Name of Insured *(if different from patient)*: | Insurance ID: | Group #

DOB of Insured _____/_____/_____ | Gender M☐ F☐ | Relationship to subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

TISSUE PATHOLOGY (check all that apply)

Specimen Source: ☐ SKIN BIOPSY ☐ BREAST BIOPSY ☐ MUSCLE BIOPSY ☐ OTHER _____

	Indicate Specimen Site and Procedure	CLINICAL IMPRESSION	RELEVANT CLINICAL HISTORY and/or Previous Pathological Findings
A.	☐ BIOPSY ☐ EXCISION ☐ OTHER		
B.	☐ BIOPSY ☐ EXCISION ☐ OTHER		
C.	☐ BIOPSY ☐ EXCISION ☐ OTHER		
D.	☐ BIOPSY ☐ EXCISION ☐ OTHER		

X

Physician's Signature *(required in NY, NJ, MA and PA)* Date

NOTE: SPECIMEN CONTAINERS MUST INCLUDE PATIENT NAME AND BIOPSY SITE