Facility/Clinic _____ **(Brown Pathology Account)**

Dr. _____

BROWN PATHOLOGY
2525 W. Bellfort Ave. Ste 120, Houston, Texas 77054
Phone 713.741.6677 Fax 713.748.5860

ANATOMIC PATHOLOGY REQUEST FORM

Billing To:
☐ Clinic ☐ Patient/Patient's Insurance
☐ Hospital ☐ Physician

Physician's Name (Last) (First) (MI)
UPIN | NPI #

Patient's Name (Last) (First) (MI) | Race | Sex | Date of Birth | Medical Record #
Patient's Address | City | State | Zip | Phone
Patient's Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other _____ | Name of Guarantor (if different from patient) | Sex | Date of Birth
Guarantor's Address | City | State | Zip | Phone
Insurance Name | Address | City | State | Zip | Phone
Subscriber/Member # | Group # | Guarantor's Employer Name | **Guarantor's SSN**
Medicare # (include prefix/suffix) ☐ Primary ☐ Secondary | Medicaid # State ☐ Primary ☐ Secondary

SURGICAL PATHOLOGY AND NON-GYNECOLOGICAL CYTOLOGY

Specimen Collection **Time** ____ : ____ **am or pm**
Formalin Immersion **Time** ____ : ____ **am or pm** **Date** ____ / ____ / ____ ICD-9 Code/Diagnosis _____

Non-Gynecological Cytology Specimen Source (Check All That Apply):

☐ BODY FLUID: ☐ Right Pleural ☐ Left Pleural ☐ Peritoneal ☐ Cerebrospinal ☐ Pericardial
☐ BRONCHIAL: (subsite: _____lobe) ☐ Wash ☐ Brush ☐ Lavage ☐ Aspirate
☐ FNA (site: _____) ☐ SPUTUM ☐ URINE ☐ OTHER _____

Surgical Pathology Tissue/Site/Source (Please List):

1 (a) _____ 6 (f) _____
2 (b) _____ 7 (g) _____
3 (c) _____ 8 (h) _____
4 (d) _____ 9 (i) _____
5 (e) _____ 10 (j) _____

Clinical Suspicions _____

Pertinent Clinical Hx _____

Additional Tests/Special Instructions _____

Previous Biopsy? ☐ Yes ☐ No Date ____ / ____ / ____ Accompanying Non-Gyn Cytology? ☐ Yes ☐ No