Form Instructions | Print | Save | Reset Form

Atrium Health Wake Forest Baptist Medical Center
Medical Center Boulevard Winston-Salem, NC 27157 (336)
716-2628 (Anatomic Pathology)
(336) 716-7595 (Fax)
http://www.wakehealth.edu/specialty/p/Pathology

Client:	Clinic/Group Name:	
	Address:	
	City, State, ZIP:	
	Fax:	Phone:
	Contact:	Email:

Surgical Pathology Request Form

This form is for Surgical Pathology requests ONLY. Form MUST be completed in its entirety (or information attached) in order to provide pathology services. Incomplete information will delay processing. Complete additional form for additional specimens.

PATIENT INFORMATION

Name: *Last Name*	*First Name*	*Middle*	*Mother's First Name*	Soc. Sec. Number (*last four digits*):	
Marital Status:	Race:	Sex: ☐ Male ☐ Female		Date of birth:	
Address:	City:			State:	ZIP:
Phone:	Employer:			Employer Phone:	

BILLING AND INSURANCE INFORMATION

Bill To:
Check box(es) & provide details below. Copies of front AND back of insurance card(s) is acceptable substitute.

Primary Insurance: ☐ Medicare ☐ Medicaid ☐ Other *(specify below)*
Secondary Insurance: ☐ Medicare ☐ Medicaid ☐ Other *(specify below)*
☐ **Bill Client**

Complete for all insurers:	**Subscriber Name:**		**Relationship to patient:**
	Policy/ID Number:		
Medicare Information:	Hospital insurance effective date:	Medical insurance effective date:	
	☐ Patient has a signed Advanced Beneficiary Notice (ABN) on file		
Medicaid Information:	Carolina Access Number:	Valid from:	To:
	State issued if NOT North Carolina:		
All other insurance information:	Insurance Company:		Phone:
	Address for Claims:		Plan Number:
	City/State/ZIP:		Effective Date:

PHYSICIAN INFORMATION

Ordering Physician (*please print*):		PCP Name:
Ordering Physician Phone:	Ordering Physician Fax:	PCP Fax:
Ordering Physician Signature:	Date: Time:	☐ Fax copy of report to Primary Care Provider

SPECIMEN INFORMATION

☐ **URGENT, please call results to:** **Attention:**

Specimen 1	Specimen 2	Specimen 3
Collection Date/Time:	Collection Date/Time:	Collection Date/Time:
Specimen Source/Site:	Specimen Source/Site:	Specimen Source/Site:
Chief Complaint:	Chief Complaint:	Chief Complaint:
Pre-operative Diagnosis:	Pre-operative Diagnosis:	Pre-operative Diagnosis:
Diagnosis code/verbiage:	Diagnosis code/verbiage:	Diagnosis code/verbiage:
Pertinent clinical information, clinical description, additional comments:	Pertinent clinical information, clinical description, additional comments:	Pertinent clinical information, clinical description, additional comments: