Northwestern Medicine®

REQUISITION FORM

Surgical Pathology, Cytopathology, and Hematopathology

Additional Ancillary Studies Requested on Archived Case

Archived Case > 30 days post sign-out

First Name: ______________________ Last Name: ______________________

MRN: ______________________ Date of Birth: ______________________

Case Number: ______________________

Date Ordered: ______________________

Pathologist: ______________________

Referring Physician: ______________________

Referring Physician Email: ______________________

Referring Physician Phone: ______________________

Test Requested: ______________________

Diagnosis Code: ______________________

BILLING INFORMATION

Bill to: ☐ Corporate Account: ______________________ ☐ Patient – please see below

INSURANCE INFORMATION

** If the patient has not been seen at NMH/NMG within the last 90 days, please complete the information below or provide a **copy** of the patient's insurance card.

Insurance Provider: ______________________

Policy Holder Name: ______________________ Policy Holder Date of Birth: ______________________

Policy Number: ______________________ Group Number: ______________________

Please send completed form to NMH Surgical Pathology Send Out via:
Email: SurgPathSendOut@nmh.org or click
E-Fax: 312-694-8731
Questions regarding completing the form, call 312-926-7002.