

# North Country Hospital – Lab

\* 189 Prouty Drive \* Newport, VT 05855

## Pathology & Laboratory Requisition

\* ph: 802-334-3222 \* fx: 802-334-3230

Clinician Signature \_\_\_\_\_

**Patient Name** \_\_\_\_\_

Patient Label Area

PCP/Copy to: \_\_\_\_\_

**DOB:** \_\_\_\_\_ **MR#** \_\_\_\_\_

Gender:        M        F        **SS#** \_\_\_\_\_

**Specimen Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Insurance Co. \_\_\_\_\_

OR Tissue Verification \_\_\_\_\_

Group No: \_\_\_\_\_ Ins No: \_\_\_\_\_

LMP \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PREoperative Dx: \_\_\_\_\_

Clinical Information: \_\_\_\_\_

### Surgical Pathology [Specimen Source clearly indicated]:

Specimen in Container?

- A. \_\_\_\_\_ [ ] Yes \_\_\_\_\_
- B. \_\_\_\_\_ [ ] Yes \_\_\_\_\_
- C. \_\_\_\_\_ [ ] Yes \_\_\_\_\_
- D. \_\_\_\_\_ [ ] Yes \_\_\_\_\_
- E. \_\_\_\_\_ [ ] Yes \_\_\_\_\_
- F. \_\_\_\_\_ [ ] Yes \_\_\_\_\_
- G. \_\_\_\_\_ [ ] Yes \_\_\_\_\_
- H. \_\_\_\_\_ [ ] Yes \_\_\_\_\_

Other Tests: \_\_\_\_\_

When ordering tests for which Medicare reimbursement is being sought, clinicians are reminded to request those tests that are medically necessary for diagnosis, rather than for screening purposes.



Lab Use Only – Number of Specimen Container(s) \_\_\_\_\_