EIV DIAGNOSTICS

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Fresno, CA 93711
(559) 777-7117
Fax (559) 777-7110

ANATOMIC PATHOLOGY REQUEST

PATIENT INFORMATION

Name _____ Submitting Physician _____
LAST (Please Print) FIRST MI

Address _____ Copy To _____

_____ Date Of Birth _____
CITY STATE ZIP

Sex: ☐ Female ☐ Male Patient Phone # _____ MRN/PT#: _____

Insurance Card Copy REQUIRED (Front & Back)

☐ Insurance (See Attached) ☐ Medicare _____ **Waiver on Back (ABN)**

☐ Medicaid _____ ☐ Patient (Self-Pay)

☐ Workman's Comp. Claim# _____ Employer Name _____

Employer Address _____

SPECIMEN INFORMATION

Collection Date: ____/____/____ Collection Time: _____ ☐ AM ☐ PM

Diagnosis/ICD-10 _____

SPECIMEN: A. _____

B. _____

C. _____

D. _____

E. _____

F. _____

G. _____

H. _____

I. _____

J. _____

History _____

_____

_____

Physician Signature _____ Date _____