

Corewell Health Laboratories Pathology Reviews and Consults

35 Michigan St. MC056 PATHOLOGY Grand Rapids, MI 49503
 Phone: 616-267-2660 Fax: 616-267-2661 Call Center Phone: 616-774-7721



We require a valid written order. Please fax this order to the service site listed below immediately to ensure the best patient care: Corewell Health Pathology Department: 616-267-2661

Patient Information	Last Name	First Name	MI	Sending Institution	Institution Name	Institution Phone
	Sex	Date of Birth	Phone		Contact Name	Contact Phone
	Patient Address				Institution Address	
	City	State	Zip		City	State

Send Reports to	Requesting Physician (Primary):	Phone	Fax	NPI #
	Referring Physician/Surgeon:	Phone	Fax	NPI #
	Referring Pathologist:	Phone	Fax	NPI #
	Additional Reports to:	Phone	Fax	NPI #

Billing Information	Payment Options: <input type="checkbox"/> Patient Insurance (outpatient) <input type="checkbox"/> Self-Pay (no insurance) <input type="checkbox"/> Institutional <input type="checkbox"/> Client Specialty Billing _____					
	Primary Insurance			Secondary Insurance		
	ID/Policy #	Group #	ID/Policy #	Group #		
	Insurance address	Phone	Insurance address	Phone		
	City/State/Zip			City/State/Zip		
	Insured's Name	DOB	Relation to Pt:	Insured's Name	DOB	Relation to Pt:

Signs/Symptoms/Reason for doing Procedure/ICD10 Code:

(Note: "Rule Out" "Possible" "Suspected" or "Probable" cannot be used as diagnoses for outpatient lab orders)

Specimen Information – If you run out of room, please use a second form and attach					Attach: <input type="checkbox"/> Report <input type="checkbox"/> Demographics
Medium:	#	Outside Accession/Case #	Specimen Source (ex. Right/Left Calf skin, etc.)	Collect Date	Case Type: <input type="checkbox"/> Slide Review Dr.: Clinic: Appt Date: <input type="checkbox"/> Slide Consult _____ <input type="checkbox"/> Breast/Gyn Pathology <input type="checkbox"/> Bone/Soft Tissue <input type="checkbox"/> Cardiac <input type="checkbox"/> Cytology & Cervical Biopsies <input type="checkbox"/> Dermatopathology <input type="checkbox"/> GI Pathology <input type="checkbox"/> GU Pathology <input type="checkbox"/> Renal <input type="checkbox"/> Other:
<input type="checkbox"/> Slides <input type="checkbox"/> Blocks					
<input type="checkbox"/> Slides <input type="checkbox"/> Blocks					
<input type="checkbox"/> Slides <input type="checkbox"/> Blocks					
<input type="checkbox"/> Slides <input type="checkbox"/> Blocks					
<input type="checkbox"/> Wet Tissue					
Additional Comments or Related History? (optional)					
Physician Signature Required					
Submitting a specimen with this requisition form indicates familiarity and agreement with applicable Reference Laboratory Services Policies					
Signature:					Date: