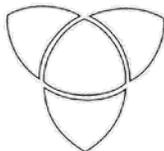


Contracted Facilities Only - Name, Address & Telephone:



Brown & Associates
medical laboratories, L.L.P.

2525 W. Bellfort Street, Suite 120, Houston, Texas 77054
Phone 713.741.6677 Fax 713.748.5860

PATHOLOGY REQUEST FORM

Billing To:
 Clinic Patient/Patient's Insurance
 Hospital Physician

Physician's Name (Last) (First) (MI)
UPIN NPI #

Patient's Name (Last) (First) (MI) Race Sex Date of Birth Medical Record #
Patient's Address City State Zip Phone
Patient's Relationship to Responsible Party Name of Responsible Party (if different from patient) Sex Date of Birth
 Self Spouse Child Other
Address of Responsible Party City State Zip Phone
Insurance Name Address City State Zip Phone
Subscriber/Member # Group # Insured's Employer Name Responsible Party's SSN
Medicare # (include prefix/suffix) Primary Secondary Medicaid # State Primary Secondary

HISTOLOGY/NON-GYNECOLOGICAL CYTOLOGY

Specimen Collection Time ____ : ____ am or pm Date ____ / ____ / ____ ICD-9 Code/Diagnosis _____

Non-Gyn Cytology Specimen Source (Check All That Apply):

BODY FLUID: Right Pleural Left Pleural Peritoneal Cerebrospinal Pericardial
 BRONCHIAL: (subsite: _____ lobe) Wash Brush Lavage Aspirate
 FNA (site: _____) SPUTUM URINE OTHER _____

Histology Tissue/Site/Source (Please List):

1 (a) _____ 6 (f) _____
2 (b) _____ 7 (g) _____
3 (c) _____ 8 (h) _____
4 (d) _____ 9 (i) _____
5 (e) _____ 10 (j) _____

Clinical Suspicions _____

Pertinent Clinical Hx _____

Additional Tests/Special Instructions _____

Previous Biopsy? Yes No Date ____ / ____ / ____ Accompanying Cytology? Yes No