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)		Medicaid #	State	
	☐ Primary ☐ Secondary			☐ 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