**SPOKANE** (509) 892-2700/(888) 814-6277
FAX (509) 892-2740
**TUKWILA** (425) 646-0922/(877) 288-0922
FAX (425) 646-0925
**RICHLAND** (509) 392-5920/(833) 369-7268
FAX (509) 866-5020

LAB NUMBER

| CHART #/MRN | DATE OF COLLECTION | SEX ☐ M ☐ F |
|---|---|---|

**PATIENT'S NAME (Last Name, First Name, Middle Initial)**

**ADDRESS**

**CITY** **STATE** **ZIP** **PHONE**

**PATIENT SOCIAL SECURITY #**

Please write N/A if SSN is unavailable

**PATIENT BIRTHDATE**

**COPY TO:**

First Name Last Name Location/Phone

**INSURANCE DETAILS (Attach Front/Back Copy of Insurance Card)**

INSURANCE NAME: POLICY/SUBSCRIBER ID #:

CLAIMS ADDRESS: GROUP #:

☐ NO INSURANCE, BILL PATIENT

☐ CLINIC DIRECT BILL

**ICD-10 CODE(S) REQUIRED** PLEASE INDICATE DIAGNOSIS CODE(S) RELATING TO THE CURRENT PROCEDURE

**PREAUTHORIZATION NUMBER**

**PREVIOUS TISSUE SENT TO OTHER LAB?** ☐ No ☐ Yes (Please attach copy of report)

**LAB USE**

DATE RECEIVED

BILLING CODES

PREP _____

## GASTROENTEROLOGY PATHOLOGY

**Pertinent History/Clinical Impression:** _____

## SPECIAL REQUESTS

**Rule Out:**

**Special Tests:**

HER2 by: ☐ IHC ☐ FISH

☐ MMR (MSI IHC Panel)

☐ H. pylori by IHC

## SITES / FINDINGS - Please identify each vial with the corresponding number below

| SPECIMEN | TYPE | | | | UPPER GI | | | | | | | | | | | | | | LOWER GI | | | | | | | | | | | | | |