The Delta Pathology Group, L.L.C.

Alexandria
211 Fourth St.
Alexandria, LA 71301
318-769-3219 Tel
318-769-3907 Fax

Lafayette
4801 Ambassador Caffery
Lafayette, LA 70508
337-470-4638 Tel
337-470-4051 Fax

Monroe
309 Jackson St.
Monroe, LA 71201
318-966-4105 Tel
318-966-4423 Fax

Greater New Orleans
1141 Whitney Ave. Bldg 3
Gretna, LA 70056
504-361-3757 Tel
504-361-3132 Fax

Shreveport
2915 Missouri Ave.
Shreveport, LA 71109
318-621-8820 Tel
318-212-4189 Fax

Toll Free:
1-800-530-5088

HISTOLOGY
EXAMINATION REQUEST

PATIENT INFORMATION

Print Firmly & Clearly or Use Addressograph

Last Name | First | MI

Address

City | State | ZIP

Social Security Number

Medical Record Number | Phone Number

Date of Birth | ___ Male | ___ Female

Physician Last Name, First, MI

Additional Report To:

Nurse

Collection Date	Time	Room #	ID #

BILLING INFORMATION

BILL TO: ☐ Patient ☐ Medicare ☐ Medicaid ☐ Other

Subscriber Name | Primary Care Physician

Medicare Number | Suffix(s)

Copy of FRONT & BACK of Cards Preferred

Medicaid Number | State

Policy Number | Group Number

Primary Insurance Company

Address

Secondary Insurance Company | Policy Number | Group Number

Address

☐ GROSS AND MICROSCOPIC EXAM
☐ FROZEN SECTION
☐ BONE MARROW
☐ LPIC ☐ RPIC
☐ FLOW CYTOMETRY
☐ CYTOGENETICS
☐ DIRECT IMMUNOFLUORESCENCE
☐ GROSS EXAM ONLY
☐ FISH _____
☐ OTHER _____

SPECIMEN(S) SUBMITTED

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

CLINICAL DIAGNOSIS / PATIENT HISTORY

LAB USE ONLY ☐ FROZEN ☐ ORC W/O FROZEN ☐ ORC TOUCH PREP

DIAGNOSIS:

No. of Containers Submitted

LAB USE ONLY - ACCESSION NO

INITIALS _____

H&E QC Acceptable _____ Time in _____ Time out _____ Cryostat temp _____ Patient identification confirmed _____

The results of the Frozen Section examination were reported to the physician listed above on today's date at the time indicated.