



Specimen Submission Form

<i>Clinician's Information</i>			
Clinician's Name			
Healthcare Institute			
Address			
Contact Phone No			
Email			
Fax			
Patient's information			
Legal Name ¹			
	Last Name	First Name	
Date of Birth		Sex	
Address (Street, City, State, Zip)			
Phone			
Insurance Company			
Member ID ²			
Group #			
Insured name			
Date of Procedure/Date of collection and time (time of collection must be entered for breast tissue)			
Procedure description			
Biopsy site			
Clinical Impression (to include any pertinent medical history, previous pathology or clinical information when appropriate. Necessary for billing purposes)			
Physician's request			
Physician's signature			

Note:

1. If prior specimens have been submitted with another name within the past ten years, please include
2. An attached copy of insurance card is