☐ RUSH

PATHOLOGY ASSOCIATES
The Mount Sinai School of Medicine
The Mount Sinai Laboratory
1428-30 Madison Avenue
New York, New York 10029
(212) 241-0440

ACCESSION NUMBER (LABORATORY COMPLETES)

DATE OF PROCEDURE: ____/____/____

TIME OF PROCEDURE: ____AM/PM

REQUESTING DOCTOR | DICT.# | MT. SINAI PATIENT IDENTIFICATION #

PATIENT NAME FIRST NAME | LAST NAME | DATE OF BIRTH

STREET | APT. # | HOME PHONE

CITY | STATE | ZIP | AGE/SEX

MEDICARE #:
MEDICARE PT MUST SIGN BACK OF THIS FORM

OTHER INSURANCE #S:
PT MAY ASSIGN BENEFITS ON BACK OF FORM

Clinical Diagnosis and Information

ANATOMIC DRAWING/NOTES

LMP (Date)

Hormone Rx:

SITE OF SPECIMEN(S)

A ____ E ____

B ____ F ____

C ____ G ____

D ____ H ____

To Specify Pathologist

Att. Dr.

DO NOT WRITE BELOW THIS LINE