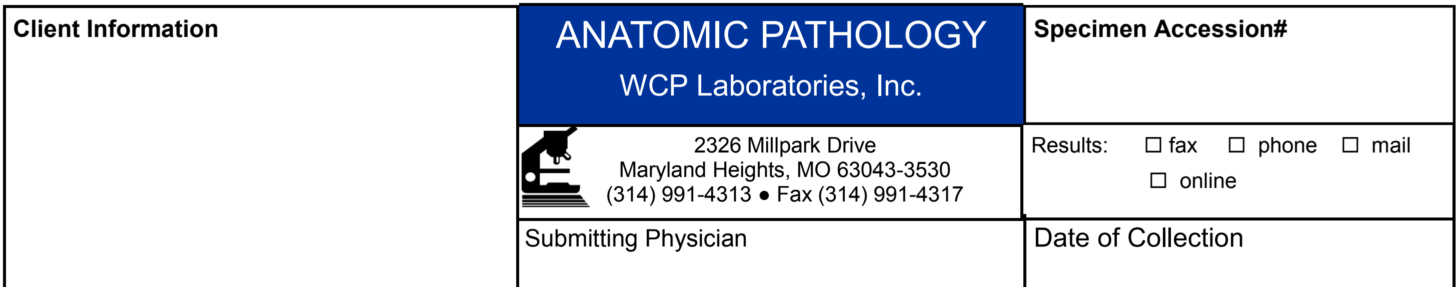

Client Information

ANATOMIC PATHOLOGY

WCP Laboratories, Inc.

2326 Millpark Drive
Maryland Heights, MO 63043-3530
(314) 991-4313 • Fax (314) 991-4317

Specimen Accession#

Results: ☐ fax ☐ phone ☐ mail ☐ online

Submitting Physician

Date of Collection

PATIENT INFORMATION / PAYMENT INFORMATION

Last Name | First Name | MI

Street Address | City, State | Zip Code

Patient Telephone # | Date of Birth (MM/DD/YYYY) | Patient Signature

SSN - - | **Gender:** ☐Male ☐Female | **Race:** ☐White ☐Black ☐Asian ☐Hispanic ☐Other

BILL TO:
- ☐ **Insurance** ☐ **Patient**
- ☐ **Medicare** ☐ **Client**
- ☐ **Medicaid** ☐ **Other**

PLEASE ATTACH INSURANCE CARD COPY

Insurance Company & Address

Group # | Patient Ins. ID #

Medicare # | Medicaid #

I have read and understand the ABN on reverse side.
Patient Initials__________________

Last Name of Guarantor | First Name

SSN / / | **DOB** / /

MICROBIOLOGY TESTS REQUESTED

FOR QUALITY RESULTS, SEND TISSUE AND FLUIDS TO MICROBIOLOGY WHEN AVAILABLE.
DO NOT ADD FIXATIVE TO MICROBIOLOGY SPECIMENS.

# of specimens ____________ **ICD-9** ______________________________

	Culture, Aerobic/Routine		Culture, Body fluid
	Culture, Anaerobic		Culture, Tissue
	Gram Stain ONLY		Culture, Group B Streptococcus
	Culture, Fungus		Culture, Throat
	Smear Only, Fungus / KOH		Culture, Blood
	Culture, AFB		MRSA Screen
	C. difficile Toxin		Urinalysis
	Culture, Stool		Culture, Urine

URINE

Collection Type
- ☐ First Morning Void
- ☐ Cath Urine
- ☐ Bladder Wash
- ☐ Voided Urine

Refrigerate urine not collected in gray top tubes w/ preservative. Store all other specimens at room temperature.

INFECTIOUS DISEASE

- ☐ HPV Detection (High & Low)
- ☐ N. gonorrhea by PCR (ThinPrep/Swab)
- ☐ Chlamydia by PCR (ThinPrep/Swab)
- ☐ HPV Detection (High & Low)
- ☐ Strep B by PCR
- ☐ EBV
- ☐ Herpes Simplex by PCR

NON GYN CYTOLOGY

☐ FNA
☐ Left ☐ Right ☐ Solid ☐ Cyst
Source:__________________

☐ Brushings/Washings
Source:__________________

☐ Direct Smear (Tzanck, etc.)

☐ Nipple Discharge

☐ Sputum

☐ Other:________________

PATHOLOGY REQUESTED

CLINICAL HISTORY ***Pre-Op Diagnosis:*** ***Post-Op Diagnosis:***

☐ **Diagnostic Biopsy** ☐ **Excisional Biopsy** ☐ **Examine Surgical Margins** **# of specimens** ________ **ICD-9 Codes:** ______________

Specimen(s)

1 ____

2 ____

3 ____

4 ____

5 ____

Time in formalin:__________
(Breast cases only)

Comments:

Additional Testing:
- ☐ **FLOW CYTOMETRY** ☐ **POC FOR CHROMOSOME ANALYSIS**
- ☐ **BREAST PROFILE** ☐ **IMMUNOHISTOCHEMISTRY STAINS**