


Client Information	ANATOMIC PATHOLOGY WCP Laboratories, Inc.		Specimen Accession#
	 2326 Millpark Drive Maryland Heights, MO 63043-3530 (314) 991-4313 • Fax (314) 991-4317		Results: <input type="checkbox"/> fax <input type="checkbox"/> phone <input type="checkbox"/> mail <input type="checkbox"/> online
	Submitting Physician		Date of Collection

PATIENT INFORMATION	PAYMENT INFORMATION
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Last Name		First Name		MI	
Street Address			City, State		Zip Code
Patient Telephone #		Date of Birth (MM/DD/YYYY)		Patient Signature	
SSN - -		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	
BILL TO: <input type="checkbox"/> Insurance <input type="checkbox"/> Patient <input type="checkbox"/> Medicare <input type="checkbox"/> Client <input type="checkbox"/> Medicaid <input type="checkbox"/> Other		Insurance Company & Address		Group # Patient Ins. ID #	
PLEASE ATTACH INSURANCE CARD COPY				Medicare # Medicaid #	
I have read and understand the ABN on reverse side.		Last Name of Guarantor		First Name	
Patient Initials _____		SSN / /		DOB / /	

MICROBIOLOGY TESTS REQUESTED	INFECTIOUS DISEASE																	
FOR QUALITY RESULTS, SEND TISSUE AND FLUIDS TO MICROBIOLOGY WHEN AVAILABLE. DO NOT ADD FIXATIVE TO MICROBIOLOGY SPECIMENS.																		
# of specimens _____ ICD-9 _____	<input type="checkbox"/> HPV Detection (High & Low) <input type="checkbox"/> Strep B by PCR (Swab) <input type="checkbox"/> N. gonorrhea by PCR (ThinPrep/Swab) <input type="checkbox"/> EBV <input type="checkbox"/> Chlamydia by PCR (ThinPrep/Swab) <input type="checkbox"/> Herpes Simplex by PCR (M4)																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Culture, Aerobic/Routine</td> <td style="width: 25%;">Culture, Body fluid</td> <td rowspan="8" style="width: 50%; text-align: center; vertical-align: middle;"> URINE <i>Collection Type</i> <input type="checkbox"/> First Morning Void <input type="checkbox"/> Cath Urine <input type="checkbox"/> Bladder Wash <input type="checkbox"/> Voided Urine <small>*Refrigerate urine not collected in gray top tubes w/ preservative. Store all other specimens at room temperature.*</small> </td> </tr> <tr> <td>Culture, Anaerobic</td> <td>Culture, Tissue</td> </tr> <tr> <td>Gram Stain ONLY</td> <td>Culture, Group B Streptococcus</td> </tr> <tr> <td>Culture, Fungus</td> <td>Culture, Throat</td> </tr> <tr> <td>Smear Only, Fungus / KOH</td> <td>Culture, Blood</td> </tr> <tr> <td>Culture, AFB</td> <td>MRSA Screen</td> </tr> <tr> <td>C. difficile Toxin</td> <td>Urinalysis</td> </tr> <tr> <td>Culture, Stool</td> <td>Culture, Urine</td> </tr> </table>	Culture, Aerobic/Routine	Culture, Body fluid	URINE <i>Collection Type</i> <input type="checkbox"/> First Morning Void <input type="checkbox"/> Cath Urine <input type="checkbox"/> Bladder Wash <input type="checkbox"/> Voided Urine <small>*Refrigerate urine not collected in gray top tubes w/ preservative. Store all other specimens at room temperature.*</small>	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	NON GYN CYTOLOGY <input type="checkbox"/> FNA <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Solid <input type="checkbox"/> Cyst Source: _____ <input type="checkbox"/> Brushings/Washings Source: _____ <input type="checkbox"/> Direct Smear (Tzanck, etc.)
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	<input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Sputum <input type="checkbox"/> Other: _____																	

PATHOLOGY REQUESTED

<i>CLINICAL HISTORY</i> Pre-Op Diagnosis:	Post-Op Diagnosis:
<input type="checkbox"/> Diagnostic Biopsy <input type="checkbox"/> Excisional Biopsy <input type="checkbox"/> Examine Surgical Margins # of specimens _____ ICD-9 Codes: _____	

Specimen(s)	Time in formalin: _____ (Breast cases only)
1 _____	Comments:
2 _____	
3 _____	
4 _____	
5 _____	

Additional Testing: <input type="checkbox"/> FLOW CYTOMETRY <input type="checkbox"/> POC FOR CHROMOSOME ANALYSIS <input type="checkbox"/> BREAST PROFILE <input type="checkbox"/> IMMUNOHISTOCHEMISTRY STAINS
