Avera McKennan Regional Laboratory

Sioux Falls Service Center
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PHYSICIANS LABORATORY
focused on excellence

Pathology Review of Peripheral Smear Request Form

Specimen Collection Date: ______________Time: ________________

Patient Name: ____
Last Name First Name MI

Age/DOB: ____________________________ Sex: M / F SSN: ________________________

Specimen ID#: _________________________ Referring Facility: ____________________________

Referring Physician: _________________________ Telephone: ____________________________

Patient Clinical Information

Diagnosis/reason for review: ____

____

ICD-9 ______________________________ Other ____________________________________

______________________________ ____________________________________

Attach copy of hemogram OR CBC results

Laboratory Use Only:

____ Inpatient (IH)
____ Outpatient (OH)

- ☐ 85060 Blood smear, peripheral, by pathologist, written report
- ☐ 87207 Special stain, inclusion bodies (Tzanck)
- ☐ Other: (describe) ____

____ ______________________________
Pathologist Date