Histopathology Test Requisition Form

Patient Information:

- **Name: _____**
- **Date of Birth: _____ Gender: _____**
- **Contact Number: _____**
- **Address: _____**

Physician Information:

- **Referring Physician: _____**
- **Contact Number: _____**
- **Clinic/Hospital Name: _____**

Specimen Details:

- **Type of Specimen: _____**
- **Site of Specimen Collection: _____**
- **Date of Specimen Collection: _____**

Clinical Information:

- **Reason for Test: _____**

- **Relevant Medical History: _____**

Test Required:

- **Biopsy**

- **Cytology**
- **Immunohistochemistry**
- **Other (Specify): _____**

Additional Notes:

_____

_____

Signature of Physician: _____

Date: _____

_____