5865 N. Michigan Road, Indianapolis, IN 46228 • Phone: (317) 255.3530 • Fax: (317) 255.3530

REQUEST REPORT

Name of Patient:

First Name *Middle Initial* *Last Name* *Patient ID (if available)*

Type of Test:

- ☐ Histology (Tissue)
- ☐ Cytology
- ☐ GC Chlamydia
- ☐ HPV
- ☐ Group B Strep
- ☐ Other:

Specimen Drawn Date:

MM/DD/YYYY

Doctor's Office:

Account Number:

Send results to:

- ☐ Name of person:
- ☐ Fax #:
- ☐ Email:
- ☐ Telephone:
- ☐ Urgent *OR* ☐ Routine

Date:

MM/DD/YYYY

Signature:

Title: