



PLEASE PRINT CLEARLY

Room No. or Dept	Patient's Surname														
	Title and Other Names														
	Date of Birth						Tel No.								
	Hospital No.														
	Consultant's Name(s)														
Nature of Specimens	Date & Time of Specimen											Sex			
	Please tick appropriate box to ensure required billing procedure						Invoice to Insurer <input type="checkbox"/>		Dr <input type="checkbox"/>		Patient <input type="checkbox"/>				
	Previous Histology/Cytology No. (if relevant)						<input type="checkbox"/> Digital Pathology Image (please tick) NB: PMI rates will apply unless otherwise stated.						Insurance Details (PMI)		
													Address for Invoice (Patient)		
Consultant's Signature						Date/Time of specimen									