

Required Information is Highlighted

CellNetix Pathology & Laboratories



12501 E. Marginal Way S., Suite 200
 Tukwila, WA 98168
 Toll Free (866) 236-8296
 Billing (877) 340-5884
 WWW.CELLNETIX.COM
 07-21-2025

Patient Information					Specimen Information	
PATIENT LAST NAME	FIRST	M.I.	BIRTH SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	GENDER ID <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	COLLECTION DATE	TIME
PATIENT D.O.B.	PATIENT SOCIAL SECURITY NUMBER	MRN	RACE/ETHNICITY		ICD-10 CODE(S)	
STREET ADDRESS					Referring MDs	
CITY	STATE	ZIP	PHONE			
Billing Information						
INSURANCE COMPANY NAME AND ADDRESS						
CITY	STATE	ZIP				
INSURANCE/SUBSCRIBER ID#	SUBSCRIBER NAME/RESPONSIBLE PARTY					
INSURANCE/GROUP#	MEDICARE#	<input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY				
SECONDARY	MEDICAID (coupon attached)					
<input type="checkbox"/> NO INSURANCE	WORKER'S COMP	<input type="checkbox"/> YES <input type="checkbox"/> NO				
INTERNAL USE ONLY						
CC report to:					First and Last Names	

HISTOLOGY

TISSUE SPECIMENS (HISTOLOGY)

Time in Formalin

A) _____	_____
B) _____	_____
C) _____	_____
D) _____	_____
E) _____	_____
F) _____	_____

CLINICAL HISTORY / OTHER INFORMATION:

ADDITIONAL TESTING:

