

**MERRIMACK VALLEY HOSPITAL  
140 LINCOLN AVENUE  
HAVERHILL, MA 01830-6798**

**978-521-8680**

**George F. Kwass, MD, Pathologist**

**Request for Pathological Examination**

**OFFICE OBTAINED SPECIMEN TESTING REQUISITION**

Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Copy Report To: \_\_\_\_\_

**Insurance Information: If attaching information in lieu of completing the following,  
Please assure Insurance Carrier is CLEARLY noted.**

Person Responsible for payment:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

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Clinical History in Brief: \_\_\_\_\_

\_\_\_\_\_

Clinical Diagnosis: \_\_\_\_\_

Source of Specimen: \_\_\_\_\_