THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

ELECTRON MICROSCOPY REQUISITION FORM
for
REFERENCE LABORATORY TESTING

SENT FROM:

Institution name: ______________________________

Address: ______________________________

City/State: ______________________________

Zip Code: ______________________________

Phone: ______________________________

Fax: ______________________________

Patient Name: ______________________________

D.O.B.: ______________________________

Age: ______________________________

Sex: ______________________________

Pt. Record No.: ______________________________

PLEASE BILL AND MAIL RESULTS TO:

Name: ______________________________

Address: ______________________________

City/State: ______________________________

Zip Code: ______________________________

Phone: ______________________________

Fax: ______________________________

Please note that we do not bill patients or insurance companies.
Billing is inter-institutional only.

Ordering Physician: ______________________

Sample Collection Date: ______________________

Sample Collection Time: ______________________

SEND TO:

Attention Dr. W.T. Gunning
Department of Pathology
University of Toledo
Health Science Campus
Block Health Sciences Bldg., Room 029
3035 Arlington Ave.
Toledo, OH 43614-5804

Laboratory phone: (419) 383 - 3484
Laboratory fax: (419) 383 - 2845

Test Ordered: ______________________________

Specimen Source: ______________________________