



**HPV Requisition Form**  
**The Johns Hopkins Medical Laboratories**  
**1620 McElderry St., Reed Hall Rm. 315 - Baltimore, MD 21205**  
**Phone: 410-955-2405**

CLIA License #21D0709511

State of Maryland License #471

Physician's Name:		Johns Hopkins History Number				Social Security Number									
				-				-							
Physician's Mailing Address (Street/Suite):		Patient Name (Last, First, MI)													
		Date of Birth:						-			-			Male ( )	
Please fax results to:	Telephone Number:	Location:				Account Number				Collection Date:					
Physician's UPIN:		Diagnosis:													
Physician's Authorized Signature:		<b>Comments:</b>													

**Surgical Pathology Consultation**

**Body Site:**

**Number of slides / blocks submitted:**

**CLINICAL INFORMATION: (Brief summary of pertinent facts)**

**ANY PREVIOUS PERTINENT PATHOLOGY:**

**SPECIAL STUDIES REQUESTED:**

**M.D.**

\_\_\_\_\_  
Signature