The Children's Hospital *of* Philadelphia

Department of Pathology and Laboratory Medicine
Division of Anatomic Pathology

Anti-Enterocyte Antibody Requisition

Patient Information *(Required)*	Provider Information *(Required)*
Patient Name:	Referring Institution:
Address:	Address:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone:	Phone: Fax:
DOB: ☐ Male ☐ Female	Referring Physician
	Phone:
	E-Mail:

Specimen Information *(Required)*

Specimen ID#: _____
Number of Serum(s) sent: _____
Biopsy site of slides sent: _____
Date serum obtained: _____

Send All Specimens To:
Division of Anatomic Pathology
Department of Pathology and Laboratory Medicine
Children's Hospital of Philadelphia
34th Street and Civic Center Blvd.
Philadelphia PA 19104-4318
215-590-1728

Information Relevant To Current Problem *(Required)*

Please include complete copy of the patient's pathology report, as well as report or copies of relevant imaging studies.

Referring Diagnosis:

Clinical History:

Billing Information (Required)

***Please note at this time we are not able to bill the patient's insurance directly for any services we provide ***

Referring Institution Billing Contact Person:

Billing Address:

City, State, Zip:

Phone: Fax: E-Mail:

CHOP Internal Use Only

Date Received: Received By: CHOP ID:

Assigned Pathologist:

Comments: