REQUISITION

DERMATOPATHOLOGY & ORAL PATHOLOGY REQUISITION FORM – WET/FRESH TISSUE SUBMISSION

Patient Identification Information

☐ **Dermatopathology** ☐ **Oral Pathology**

PATIENT INFORMATION

Patient Name:_____

Address:_____ City/State/Zip:_____

Telephone No:_____ DOB: Mo_____ Day_____ Yr_____ Race_____ Sex_____

GUARANTOR/BILL TO ☐ Same as patient Guarantor Name:_____

Address:_____ City/State/Zip:_____

Guarantor DOB: Mo_____ Day_____ Yr_____ Relationship to patient:_____

MEDICAL Insurance: Please attach a copy of the card. **(We will not be able to process the specimen through your dental insurance company.)**

☐ **Self pay/ No insurance**

Insurance Company:_____ **Member ID:**_____

Subscriber Name:_____ **DOB:**_____

PATIENT/GUARANTOR AUTHORIZATION I acknowledge my responsibility for all charges for these laboratory services requested on my behalf by my physician and authorize the release of information, including medical information, for this and any related claim, to the named insurance company. I also promise to pay for all charges for any of these laboratory services that are not covered or are only partially covered/authorized by my insurance or Health Maintenance Organization.

Subscriber/ Beneficiary Signature:_____ Date:_____

SUBMITTING DOCTOR

Name: _____ NPI:_____

Address:_____ City/State/Zip:_____

Telephone No:_____ Fax No:_____

CLINICAL INFORMATION

Clinical description/history:

PLEASE FILL IN ALL BLANKS

Special Stains/studies requested

_____

Biopsy for alopecia requiring horizontal sections?

☐ Yes ☐ No

Immunofluorescence/specimen(s) sent separately?

☐ Yes ☐ No

Biopsy Site (Must EXACTLY match label on specimen container)	Procedure (Select One)	Clinical Diagnosis
	☐ Punch ☐ Incisional ☐ Shave ☐ Excisional ☐ Excision ☐ Enucleation	
	☐ Punch ☐ Incisional ☐ Shave ☐ Excisional ☐ Excision ☐ Enucleation	
	☐ Punch ☐ Incisional ☐ Shave ☐ Excisional ☐ Excision ☐ Enucleation	

SPECIMEN COLLECTION DATE & TIME

_____

SUBMITTING/REQUESTING PHYSICIAN'S SIGNATURE

_____ Date:_____