

D010652

**PHYSICIAN INFORMATION**

**AUTHORIZED SIGNATURE** \_\_\_\_\_

Copy of report to: Dr. \_\_\_\_\_ Address \_\_\_\_\_ Fax # \_\_\_\_\_

**PATIENT INFORMATION** Please write or affix label

Name (Last, First, Middle) \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_ SSN/MR # \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**BILLING INFORMATION** Please attach face sheet or copy of insurance

Bill:  Insurance  Medicare  Medicaid  Patient  Client Bill

Primary Insurance Carrier \_\_\_\_\_ Policy# / ID# \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_ Policy# / ID# \_\_\_\_\_

**DERMATOLOGY TISSUE EXAMINATION REQUEST**

Pathology Diagnosis, Wet Tissue  Second Opinion/Consultation, Slides Enclosed  
 Pathology Diagnosis, Slides  Second Opinion/Consultation, Prepare Slide from  
Block \_\_\_\_\_ located at \_\_\_\_\_ Lab \_\_\_\_\_

**SPECIMEN INFORMATION** Collection Date and Time: \_\_\_\_\_

**A. Specimen Location** \_\_\_\_\_ Shave/Punch/Excision \_\_\_\_\_

Clinical Impression/Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_

For Tumor:  Size  Pigmented  Suspicion Index 1 2 3  
For Rash:  Acute/Chronic  Single/Multiple  Any Current Treatment

**B. Specimen Location** \_\_\_\_\_ Shave/Punch/Excision \_\_\_\_\_

Clinical Impression/Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_

For Tumor:  Size  Pigmented  Suspicion Index 1 2 3  
For Rash:  Acute/Chronic  Single/Multiple  Any Current Treatment

**C. Specimen Location** \_\_\_\_\_ Shave/Punch/Excision \_\_\_\_\_

Clinical Impression/Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_

For Tumor:  Size  Pigmented  Suspicion Index 1 2 3  
For Rash:  Acute/Chronic  Single/Multiple  Any Current Treatment

**D. Specimen Location** \_\_\_\_\_ Shave/Punch/Excision \_\_\_\_\_

Clinical Impression/Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_

For Tumor:  Size  Pigmented  Suspicion Index 1 2 3  
For Rash:  Acute/Chronic  Single/Multiple  Any Current Treatment

**E. Specimen Location** \_\_\_\_\_ Shave/Punch/Excision \_\_\_\_\_

Clinical Impression/Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_

For Tumor:  Size  Pigmented  Suspicion Index 1 2 3  
For Rash:  Acute/Chronic  Single/Multiple  Any Current Treatment

**SUPPLY REQUEST:** For additional supplies please contact client services at 1-800-899-8480

DR2012V1

1. Complete the requisition with all requested information. 2. Remove the required number of labels from the front of this sheet. 3. Place one (1) label on each specimen container (not on the lid). 4. Please dispose unused labels. Note: Please label each specimen with patient's name and site.

D010652 \_\_\_\_\_ Location \_\_\_\_\_  
Patient Name \_\_\_\_\_

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Patient Name \_\_\_\_\_

D010652 \_\_\_\_\_ Location \_\_\_\_\_  
Patient Name \_\_\_\_\_

D010652 F \_\_\_\_\_ CM  
Location \_\_\_\_\_  
Patient Name \_\_\_\_\_

D010652 G \_\_\_\_\_ CM  
Location \_\_\_\_\_  
Patient Name \_\_\_\_\_

D010652 \_\_\_\_\_ Location \_\_\_\_\_  
Patient Name \_\_\_\_\_

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