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DERMATOPATHOLOGY REQUISITION

_____ OF _____ RESEARCH TECHNICAL ONLY

DATE _____ NAME _____ LAST _____ FIRST _____ () DAYTIME PHONE _____

ADDRESS _____ STREET/APT.# _____ CITY _____ ST _____ ZIP CODE _____ SS# _____

DOB _____ SEX _____ RACE _____ IMMUNOFLUORESCENCE RUSH
 PREVIOUS BIOPSY _____ MYCOLOGY (SEE BELOW)

CLINICAL INFORMATION

SITE OF SPECIMEN	CHECK:	CLINICAL DIAGNOSIS AND HISTORY	MARGINS	FOR LAB USE ONLY
A	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER		<input type="checkbox"/>	
B	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER		<input type="checkbox"/>	
C	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER		<input type="checkbox"/>	
D	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER		<input type="checkbox"/>	

BILLING / INSURANCE INFORMATION

Bill: <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Hospital <input type="checkbox"/> Other	SUBSCRIBER PRIMARY INSURANCE			SUBSCRIBER SECONDARY INSURANCE				
	SUBSCRIBER NAME / RELATIONSHIP TO SUBSCRIBER: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			SUBSCRIBER NAME / RELATIONSHIP TO SUBSCRIBER: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent				
	INSURANCE COMPANY NAME			INSURANCE COMPANY NAME				
	ADDRESS			ADDRESS				
	CITY		STATE	ZIP CODE	CITY		STATE	ZIP CODE
	EMPLOYER NAME			EMPLOYER NAME				
	SUBSCRIBER DOB:	GROUP/CONTRACT#	MEMBER ID#	SUBSCRIBER DOB:	GROUP/CONTRACT#	MEMBER ID#		
	/ /			/ /				
SUBSCRIBER SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICARE#	MEDICAID ID#	SUBSCRIBER SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICARE#	MEDICAID ID#			

INSURANCE TELEPHONE: _____

MYCOLOGY

- HISTOPATHOLOGIC ANALYSIS (H&E WITH PAS REACTION) CPT: 88305 & 88312
- FUNGAL CULTURE (SABOURAUDS AGAR) CPT: 87101 & 88312
- FUNGAL CULTURE FOLLOWED BY HISTOPATHOLOGIC ANALYSIS CPT: 87101, 88305 & 88312

SITE OF SPECIMEN	MEDIA	CLINICAL DIAGNOSIS AND HISTORY
<input type="checkbox"/> SKIN <input type="checkbox"/> NAIL <input type="checkbox"/> HAIR <input type="checkbox"/> SCALP	<input type="checkbox"/> AGAR SLANT <input type="checkbox"/> FORMALIN <input type="checkbox"/> DRY <input type="checkbox"/> SALINE	
ADDITIONAL INFORMATION: _____		

2330 Butler Street, Suite 115 • Dallas, Texas 75235 • www.skincancer.com • lab@skincancer.com

FOR DATA ENTRY ONLY:

UNKNOWN CLINICAL DEMOGRAPHICS

FOR LAB USE ONLY:

A.

Size _____ x _____ x _____

Color _____

Lesion _____

Comments _____

B.

Size _____ x _____ x _____

Color _____

Lesion _____

Comments _____

C.

Size _____ x _____ x _____

Color _____

Lesion _____

Comments _____

D.

Size _____ x _____ x _____

Color _____

Lesion _____

Comments _____

E.

Size _____ x _____ x _____

Color _____

Lesion _____

Comments _____

F.

Size _____ x _____ x _____

Color _____

Lesion _____

Comments _____

ADDITIONAL INFORMATION:

Large empty rectangular box for additional information.