PLEASE PRINT

DERMPATH DIAGNOSTICS®

THE DERMATOPATHOLOGY LABORATORY

5001 Centre Avenue • Third Floor • Pittsburgh, PA 15213

(412) 682-3083 • (800) 845-3573

(412) 682-3511 (fax)

Mandi P. Sachdeva, M.D. • John D. Miedler, M.D.

Saba M. Ali, M.D. • Trent B. Marburger, M.D.

Accession #:
(Lab Use Only)

If information is missing, conflicting, or incomplete, a call to the client to obtain and/or clarify this information will be documented.

PATIENT INFORMATION *(PLEASE PRINT)*

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		APT. #
CITY	STATE	ZIP
SOCIAL SECURITY # LAST 4 DIGITS REQUIRED		
DATE OF BIRTH REQUIRED	SEX	RACE
PATIENT'S PHONE NUMBER		

BILLING INFORMATION

ATTACH A COPY OF INSURANCE CARD(S) - BOTH SIDES - OR COMPLETE BELOW

PRIMARY INSURANCE	SECONDARY INSURANCE
COMPANY NAME:	COMPANY NAME:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP CODE:	CITY: STATE: ZIP CODE:
NAME OF POLICY HOLDER:	NAME OF POLICY HOLDER:
RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD	RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD
POLICY #: / SUBSCRIBER DOB	POLICY #: / SUBSCRIBER DOB
GROUP/CONTACT #: / SUBSCRIBER SEX ☐ MALE ☐ FEMALE	GROUP/CONTACT #: / SUBSCRIBER SEX ☐ MALE ☐ FEMALE

CLINICAL INFORMATION

DATE COLLECTED: ____ /____ /____ RELEVANT PREVIOUS Bx? ☐ No ☐ Yes CASE# _____

SITE	PLEASE CHECK:	MARGINS?	CLINICAL DIAGNOSIS & HISTORY	GROSS (Lab Use Only)
A	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		
B	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		
C	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		
D	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		

ORDER SUMMARY

☐ ROUTINE HISTOLOGY • NAIL: ☐ CULTURE ☐ PAS _____ Fungal; _____ Bacterial • ☐ IMMUNOFLUORESCENCE _____ Direct; _____ Serum (Indirect); _____ Cell markers

PHYSICIAN'S SIGNATURE (Required in NY, NJ, MA, PA and WV)

SIGNATURE _____ **DATE:** _____/ _____ / _____

Difficult cases sometimes require additional diagnostic stains to assist the dermatopathologist in making a definitive diagnosis. These diagnostic stains will result in additional charges.

SPECIMEN CONTAINER MUST CONTAIN PATIENT NAME AND SITE **PHYSICIAN MAY RETAIN PINK COPY**

PLEASE PRINT

DERMPATH DIAGNOSTICS®

THE DERMATOPATHOLOGY LABORATORY

5001 Centre Avenue • Third Floor • Pittsburgh, PA 15213

(412) 682-3083 • (800) 845-3573

(412) 682-3511 (fax)

Mandi P. Sachdeva, M.D. • John D. Miedler, M.D.

Saba M. Ali, M.D. • Trent B. Marburger, M.D.

Accession #:
(Lab Use Only)

If information is missing, conflicting, or incomplete, a call to the client to obtain and/or clarify this information will be documented.

PATIENT INFORMATION *(PLEASE PRINT)*

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		APT. #
CITY	STATE	ZIP
SOCIAL SECURITY # LAST 4 DIGITS REQUIRED		
DATE OF BIRTH REQUIRED	SEX	RACE
PATIENT'S PHONE NUMBER		

BILLING INFORMATION

ATTACH A COPY OF INSURANCE CARD(S) - BOTH SIDES - OR COMPLETE BELOW

PRIMARY INSURANCE	SECONDARY INSURANCE
COMPANY NAME:	COMPANY NAME:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP CODE:	CITY: STATE: ZIP CODE:
NAME OF POLICY HOLDER:	NAME OF POLICY HOLDER:
RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD	RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD
POLICY #: / SUBSCRIBER DOB	POLICY #: / SUBSCRIBER DOB
GROUP/CONTACT #: / SUBSCRIBER SEX ☐ MALE ☐ FEMALE	GROUP/CONTACT #: / SUBSCRIBER SEX ☐ MALE ☐ FEMALE

CLINICAL INFORMATION

DATE COLLECTED: ____ /____ /____ RELEVANT PREVIOUS Bx? ☐ No ☐ Yes CASE# _____

SITE	PLEASE CHECK:	MARGINS?	CLINICAL DIAGNOSIS & HISTORY	GROSS (Lab Use Only)
A	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		
B	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		
C	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		
D	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		

ORDER SUMMARY

☐ ROUTINE HISTOLOGY • NAIL: ☐ CULTURE ☐ PAS _____ Fungal; _____ Bacterial • ☐ IMMUNOFLUORESCENCE _____ Direct; _____ Serum (Indirect); _____ Cell markers

PHYSICIAN'S SIGNATURE (Required in NY, NJ, MA, PA and WV)

SIGNATURE _____ **DATE:** _____/ _____ / _____

Difficult cases sometimes require additional diagnostic stains to assist the dermatopathologist in making a definitive diagnosis. These diagnostic stains will result in additional charges.

SPECIMEN CONTAINER MUST CONTAIN PATIENT NAME AND SITE **PHYSICIAN MAY RETAIN PINK COPY**

PLEASE PRINT

DERMPATH DIAGNOSTICS®

THE DERMATOPATHOLOGY LABORATORY

5001 Centre Avenue • Third Floor • Pittsburgh, PA 15213

(412) 682-3083 • (800) 845-3573

(412) 682-3511 (fax)

Mandi P. Sachdeva, M.D. • John D. Miedler, M.D.

Saba M. Ali, M.D. • Trent B. Marburger, M.D.

Accession #:
(Lab Use Only)

If information is missing, conflicting, or incomplete, a call to the client to obtain and/or clarify this information will be documented.

PATIENT INFORMATION *(PLEASE PRINT)*

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		APT. #
CITY	STATE	ZIP
SOCIAL SECURITY # LAST 4 DIGITS REQUIRED		
DATE OF BIRTH REQUIRED	SEX	RACE
PATIENT'S PHONE NUMBER		

BILLING INFORMATION

ATTACH A COPY OF INSURANCE CARD(S) - BOTH SIDES - OR COMPLETE BELOW

PRIMARY INSURANCE	SECONDARY INSURANCE
COMPANY NAME:	COMPANY NAME:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP CODE:	CITY: STATE: ZIP CODE:
NAME OF POLICY HOLDER:	NAME OF POLICY HOLDER:
RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD	RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD
POLICY #: / SUBSCRIBER DOB	POLICY #: / SUBSCRIBER DOB
GROUP/CONTACT #: / SUBSCRIBER SEX ☐ MALE ☐ FEMALE	GROUP/CONTACT #: / SUBSCRIBER SEX ☐ MALE ☐ FEMALE

CLINICAL INFORMATION

DATE COLLECTED: ____ /____ /____ RELEVANT PREVIOUS Bx? ☐ No ☐ Yes CASE# _____

SITE	PLEASE CHECK:	MARGINS?	CLINICAL DIAGNOSIS & HISTORY	GROSS (Lab Use Only)
A	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		
B	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		
C	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		
D	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐		

ORDER SUMMARY

☐ ROUTINE HISTOLOGY • NAIL: ☐ CULTURE ☐ PAS _____ Fungal; _____ Bacterial • ☐ IMMUNOFLUORESCENCE _____ Direct; _____ Serum (Indirect); _____ Cell markers

PHYSICIAN'S SIGNATURE (Required in NY, NJ, MA, PA and WV)

SIGNATURE _____ **DATE:** _____/ _____ / _____

Difficult cases sometimes require additional diagnostic stains to assist the dermatopathologist in making a definitive diagnosis. These diagnostic stains will result in additional charges.

SPECIMEN CONTAINER MUST CONTAIN PATIENT NAME AND SITE **PHYSICIAN MAY RETAIN PINK COPY**