

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)

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 | | |

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

BILLING INFORMATION

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

| | | | |
|--|---|--|---|
| COMPANY NAME: PRIMARY INSURANCE | | COMPANY NAME: SECONDARY INSURANCE | |
| ADDRESS: | | ADDRESS: | |
| CITY: | STATE: | ZIP CODE: | CITY: |
| NAME OF POLICY HOLDER: | | NAME OF POLICY HOLDER: | |
| RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD | | RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD | |
| POLICY #: | SUBSCRIBER DOB | POLICY #: | SUBSCRIBER DOB |
| GROUP/CONTACT #: | SUBSCRIBER SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | GROUP/CONTACT #: | SUBSCRIBER SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |

CLINICAL INFORMATION

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

| SITE | PLEASE CHECK: | MARGINS? | CLINICAL DIAGNOSIS & HISTORY | GROSS (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"/> | | |

ORDER SUMMARY

ROUTINE HISTOLOGY • NAIL: CULTURE PAS • IMMUNOFLUORESCENCE
_____ Fungal; _____ Bacterial _____ 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

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