Dermatopathology Requisition

PATIENT INFORMATION (tinted boxes are required)			
Name (Last, First)	DOB	Sex	MRN
Address1	Address2		
City	State	Zip	Email	Phone

INSURANCE INFORMATION (tinted boxes are required)		
Subscriber Name	Subscriber DOB	Subscriber Relationship
Insurance Name	Group No.	Member No

Practitioner Signature X ____ **Date of Service** ____________

DERMATOPATHOLOGY TEST REQUEST		
	Specimen	Procedure/ Clinical Impression
A	Site: -- Procedure: ☐Shave ☐Punch ☐Excision ☐DIFpunch Other:	Clinical impression:
B	Site: -- Procedure: ☐Shave ☐Punch ☐Excision ☐DIFpunch Other:	Clinical impression:
C	Site: -- Procedure: ☐Shave ☐Punch ☐Excision ☐DIFpunch Other:	Clinical impression:
D	Site: -- Procedure: ☐Shave ☐Punch ☐Excision ☐DIFpunch Other:	Clinical impression:
E	Site: -- Procedure: ☐Shave ☐Punch ☐Excision ☐DIFpunch Other:	Clinical impression:
F	Site: -- Procedure: ☐Shave ☐Punch ☐Excision ☐DIFpunch Other:	Clinical impression: