Medical Director:
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PATIENT INFORMATION - ONE PER REQUISITION

Name (Last, First)		
Date of Birth	Sex ◯ Male ◯ Female	Last 4 SSN
Address		
City, St. Zip	Phone	

DOCTOR/CLINIC INFORMATION

☐ Hospital Facility ☐ Inpatient ☐ Skilled Nursing Home ☐ Hospice Facility
Physician Signature (Required) _____

BILLING/INSURANCE

Please attach a copy of all applicable Insurance Information. (If the patient is a minor, include Guarantor Information)

Payor ◯ Patient ◯ Insurance ◯ Client ◯ Other

Name of Insured	Relationship to Insured	
Company Name	Employer Name	
Address	Group/Contract #	Member ID #
City, St. Zip	Medicare #	Medicaid #

Copy To	Fax

SPECIMEN INFORMATION

☐ Biohazard ☐ Urgent

Specimen **A** Site | Slide # | **Collected** | ☐ Photos Enclosed

◯ Shave ◯ Punch ◯ Incision ◯ Excision ◯ Excision Suture ◯ Saucer ◯ Snip ◯ Other _____	◯ Regular Dermatopathology ◯ Consult Dermatopathology ◯ Immunofluorescence	◯ Alopecia ◯ Lesional / Perilesional ◯ Direct IF	Clinical Findings:	ICD9 Codes

SPECIMEN INFORMATION

☐ Biohazard ☐ Urgent

Specimen **B** Site | Slide # | Collected | ☐ Photos Enclosed

◯ Shave ◯ Punch ◯ Incision ◯ Excision ◯ Excision Suture ◯ Saucer ◯ Snip ◯ Other _____	◯ Regular Dermatopathology ◯ Consult Dermatopathology ◯ Immunofluorescence	◯ Alopecia ◯ Lesional / Perilesional ◯ Direct IF	Clinical Findings:	ICD9 Codes

SPECIMEN INFORMATION

☐ Biohazard ☐ Urgent

Specimen **C** Site | Slide # | Collected | ☐ Photos Enclosed

◯ Shave ◯ Punch ◯ Incision ◯ Excision ◯ Excision Suture ◯ Saucer ◯ Snip ◯ Other _____	◯ Regular Dermatopathology ◯ Consult Dermatopathology ◯ Immunofluorescence	◯ Alopecia ◯ Lesional / Perilesional ◯ Direct IF	Clinical Findings:	ICD9 Codes

SPECIMEN INFORMATION

☐ Biohazard ☐ Urgent

Specimen **D** Site | Slide # | Collected | ☐ Photos Enclosed

◯ Shave ◯ Punch ◯ Incision ◯ Excision ◯ Excision Suture ◯ Saucer ◯ Snip ◯ Other _____	◯ Regular Dermatopathology ◯ Consult Dermatopathology ◯ Immunofluorescence	◯ Alopecia ◯ Lesional / Perilesional ◯ Direct IF	Clinical Findings:	ICD9 Codes