

# DERMATOPATHOLOGY REQUISITION

## CLIENT INFORMATION



9500 Euclid Avenue / L15  
Cleveland, OH 44195  
216.444.5755 or 800.628.6816

### PATIENT INFORMATION – Screened information is required

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Patient ID \_\_\_\_\_  
Sex:  M  F \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

### BILLING INSTRUCTIONS – Must complete Sections A–E or client will be billed

**BILL TO:**  Client  Patient  Medicare  Medicaid  Other Insurance

**A** Patient address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Responsible Party/Policy holder: \_\_\_\_\_ Relation: \_\_\_\_\_  
Telephone: (\_\_\_\_\_) \_\_\_\_\_

#### B Copy Insurance Card, front and back

**C This section required if B is not provided**

	Primary Ins.	Secondary Ins.
Medicare No.: _____	<input type="checkbox"/>	<input type="checkbox"/>
Ohio Medicaid No.: _____	<input type="checkbox"/>	<input type="checkbox"/>
Insurance Name: _____	<input type="checkbox"/>	<input type="checkbox"/>
ID No.: _____ Group No.: _____		

Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Worker's Comp Claim No.: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

**D Diagnosis Code required:** 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

**E** Referring physician: \_\_\_\_\_  
NPI No. \_\_\_\_\_ UPIN: \_\_\_\_\_

Clinical History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date collected: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_

Collected by: \_\_\_\_\_

Consultation on Prepared Slides/Block

SPECIMEN A	SPECIMEN B	SPECIMEN C
<b>Check off Appropriate Type of Biopsy</b> <input type="checkbox"/> PUNCH <input type="checkbox"/> SHAVE <input type="checkbox"/> CURETTINGS <input type="checkbox"/> EXCISION <input type="checkbox"/> WIDE EXCISION <b>MARGINS:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Biopsy Site:</b> _____ _____ _____ <b>Clinical History:</b> _____ _____ _____ <b>Additional Tests:</b> <input type="checkbox"/> DIRECT IMMUNOFLUORESCENCE <input type="checkbox"/> ELECTRON MICROSCOPY <input type="checkbox"/> IMMUNOHISTOCHEMISTRY <input type="checkbox"/> LYMPHOMA	<b>Check off Appropriate Type of Biopsy</b> <input type="checkbox"/> PUNCH <input type="checkbox"/> SHAVE <input type="checkbox"/> CURETTINGS <input type="checkbox"/> EXCISION <input type="checkbox"/> WIDE EXCISION <b>MARGINS:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Biopsy Site:</b> _____ _____ _____ <b>Clinical History:</b> _____ _____ _____ <b>Additional Tests:</b> <input type="checkbox"/> DIRECT IMMUNOFLUORESCENCE <input type="checkbox"/> ELECTRON MICROSCOPY <input type="checkbox"/> IMMUNOHISTOCHEMISTRY <input type="checkbox"/> LYMPHOMA	<b>Check off Appropriate Type of Biopsy</b> <input type="checkbox"/> PUNCH <input type="checkbox"/> SHAVE <input type="checkbox"/> CURETTINGS <input type="checkbox"/> EXCISION <input type="checkbox"/> WIDE EXCISION <b>MARGINS:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Biopsy Site:</b> _____ _____ _____ <b>Clinical History:</b> _____ _____ _____ <b>Additional Tests:</b> <input type="checkbox"/> DIRECT IMMUNOFLUORESCENCE <input type="checkbox"/> ELECTRON MICROSCOPY <input type="checkbox"/> IMMUNOHISTOCHEMISTRY <input type="checkbox"/> LYMPHOMA