

**DERMATOPATHOLOGY REQUISITION**

Client Name: \_\_\_\_\_  
 Physician's Last Name, First Name  
 [ ] \_\_\_\_\_  
 [ ] \_\_\_\_\_  
 [ ] \_\_\_\_\_  
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 [ ] \_\_\_\_\_

<b>SIGNATURE OF ORDERING PROVIDER</b> (Signature must be dated, legible, and include first and last name)  _____  <b>DATE</b> _____	<b>BILLING</b> <input type="checkbox"/> PHYSICIAN / ACCOUNT <input type="checkbox"/> PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION ATTACHED <input type="checkbox"/> BCCP, ALPHA ID # _____  IF NO BILLING INFORMATION IS PROVIDED AND NO BOX IS CHECKED, YOUR ACCOUNT WILL BE BILLED.	<b>PATHOLOGY USE ONLY</b> <b>ACCESSION #</b> (place label here)
<b>CONSULTING PHYSICIAN</b> (First and Last Name)  _____		

**PATIENT INFORMATION**

Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
MO / DAY / YEAR

Patient Address \_\_\_\_\_ City, State, ZIP code \_\_\_\_\_

SSN \_\_\_\_\_ MRN \_\_\_\_\_  Inpatient  Outpatient

**CLINICAL INFORMATION**

<b>SPECIMEN 1</b>  Date of Collection _____ Time of Collection _____ <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Re-Excision <input type="checkbox"/> Alopecia Sections <input type="checkbox"/> Direct Immunofluorescence Margins: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Anatomic Site:</b>  <b>Clinical Findings:</b>  <b>Differential Diagnosis:</b>
<b>SPECIMEN 2</b>  Date of Collection _____ Time of Collection _____ <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Re-Excision <input type="checkbox"/> Alopecia Sections <input type="checkbox"/> Direct Immunofluorescence Margins: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Anatomic Site:</b>  <b>Clinical Findings:</b>  <b>Differential Diagnosis:</b>
<b>SPECIMEN 3</b>  Date of Collection _____ Time of Collection _____ <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Re-Excision <input type="checkbox"/> Alopecia Sections <input type="checkbox"/> Direct Immunofluorescence Margins: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Anatomic Site:</b>  <b>Clinical Findings:</b>  <b>Differential Diagnosis:</b>
<b>SPECIMEN 4</b>  Date of Collection _____ Time of Collection _____ <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Excision <input type="checkbox"/> Re-Excision <input type="checkbox"/> Alopecia Sections <input type="checkbox"/> Direct Immunofluorescence Margins: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Anatomic Site:</b>  <b>Clinical Findings:</b>  <b>Differential Diagnosis:</b>