SBMF
South Bend Medical Foundation
3355 Douglas Road, South Bend, IN 46635

DERMATOPATHOLOGY REQUISITION

Client Name: _____

✓ Physician's Last Name, First Name

[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____

SIGNATURE OF ORDERING PROVIDER
(Signature must be dated, legible, and include first and last name)

_____

DATE_____

CONSULTING PHYSICIAN (First and Last Name)

_____

BILLING

☐ PHYSICIAN / ACCOUNT

☐ PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION ATTACHED

☐ BCCP, ALPHA ID #_____

IF NO BILLINGINFORMATION IS PROVIDED AND NO BOX IS CHECKED, YOUR ACCOUNT WILL BE BILLED.

PATHOLOGY USE ONLY
ACCESSION #
(place label here)

PATIENT INFORMATION

Name _____ DOB_____ AGE _____ SEX _____
Last First MI MO / DAY / YEAR

Patient Address _____ City, State, ZIP code _____

SSN _____ MRN _____ ☐ Inpatient ☐ Outpatient

CLINICAL INFORMATION

SPECIMEN 1

Date of Collection _____

☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Time of Collection: _____ ☐ AM ☐ PM
Time Placed in Formalin: _____ ☐ AM ☐ PM

Clinical Findings:

Differential Diagnosis:

SPECIMEN 2

Date of Collection _____

☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Time of Collection: _____ ☐ AM ☐ PM
Time Placed in Formalin: _____ ☐ AM ☐ PM

Clinical Findings:

Differential Diagnosis:

SPECIMEN 3

Date of Collection _____

☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Time of Collection: _____ ☐ AM ☐ PM
Time Placed in Formalin: _____ ☐ AM ☐ PM

Clinical Findings:

Differential Diagnosis:

SPECIMEN 4

Date of Collection _____

☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Time of Collection: _____ ☐ AM ☐ PM
Time Placed in Formalin: _____ ☐ AM ☐ PM

Clinical Findings:

Differential Diagnosis: