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PSP USE ONLY:

DERMATOPATHOLOGY REQUEST

PATIENT INFORMATION

Last First M

SSN

Date of Birth Sex (circle one) M F

Address

City, State ZIP

Phone

PHYSICIAN INFORMATION

Date

Office site

Ordering physician

Copies to

Physician Signature

Label specimens with patient info and tissue type submitted and place in bio-bag

☐ **Bill Insurance** Please attach photocopy of patient's Insurance card ☐ **Self pay** ☐ **Client bill**

SURGICAL PATHOLOGY SPECIMEN/ICD-10

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.

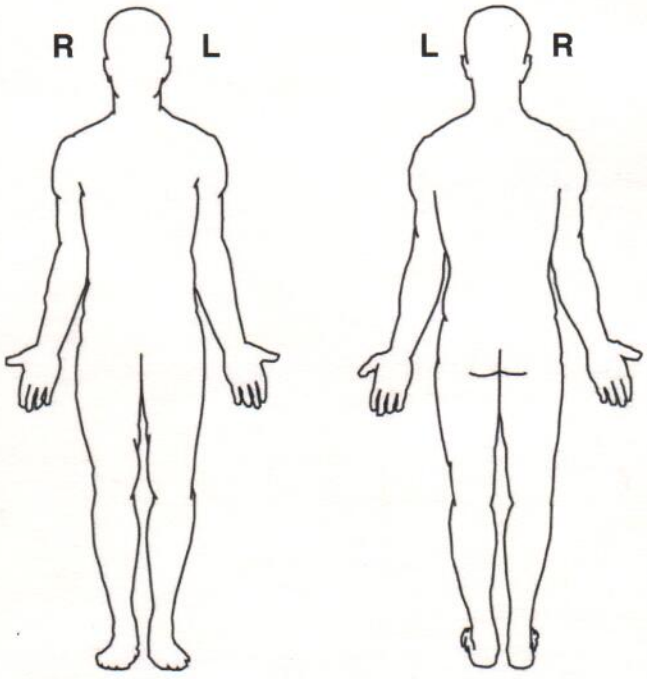
ADDITIONAL TESTS (SPECIFY SPECIMEN)

☐ **Aerobic C&S** ☐ **Anaerobic C&S**

☐ **Gout (Fresh)** ☐ **Lymphoma Studies (Fresh)**

☐ **Direct Immunofluorescence (Michel's Medium)**

☐ **Other** _____



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