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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 _____

