COCKERELL
DERMATOPATHOLOGY™
We treat every specimen as if it came from one of our own family members.

CLAY J. COCKERELL, M.D.
Medical Director

2110 RESEARCH ROW, SUITE 100
DALLAS, TX 75235

PRACTICE INFORMATION

PODIATRY REQUISITION

___/___/___ DATE COLLECTED

PATIENT ______ LAST ______ FIRST ______ MI

ADDRESS ______ STREET/APT# ______ CITY ______ ST ______ ZIP CODE ______ PHONE ______

DOB ___/___/___ SEX ______ RACE ______ PREVIOUS BIOPSY# AND DIAGNOSIS ______

INFO

CUSTOMER SERVICE
(214) 530-5200 | (800) 309-0000
INFO@DERMPATH.COM

ORDER SUPPLIES
DERMPATH.COM/SUPPLIES
214-530-5200 | 800-309-0000

SEND CLINICAL IMAGES
DERMPATH.COM/IMAGES

SPECIMEN A

SPECIMEN SITE

CLINICAL IMPRESSION | HISTORY

NAIL SPECIMEN (H&E/PAS)
☐ DYSTROPHY
☐ FUNGUS
☐ PIGMENTED|STREAKED
☐ OTHER ______

SKIN SPECIMEN (H&E/ADDT'L STAINS AS NEEDED)
☐ PIGMENTED (R/O MELANOMA)
☐ CARCINOMA (R/O BCC | SCC)
☐ DERMATITIS (PROVIDE R/O)
☐ VERUCA
☐ ULCERATION (PROVIDE R/O)
☐ OTHER ______

SOFT TISSUE|BONE SPECIMEN (H&E/ADDT'L STAINS AS NEEDED)
☐ INFLAMMATORY CONDITION
☐ TUMOR
☐ ARTHRITIC BONE
☐ LYTIC BONE LESION
☐ OTHER ______

SPECIMEN B

SPECIMEN SITE

CLINICAL IMPRESSION | HISTORY

NAIL SPECIMEN (H&E/PAS)
☐ DYSTROPHY
☐ FUNGUS
☐ PIGMENTED|STREAKED
☐ OTHER ______

SKIN SPECIMEN (H&E/ADDT'L STAINS AS NEEDED)
☐ PIGMENTED (R/O MELANOMA)
☐ CARCINOMA (R/O BCC | SCC)
☐ DERMATITIS (PROVIDE R/O)
☐ VERUCA
☐ ULCERATION (PROVIDE R/O)
☐ OTHER ______

SOFT TISSUE|BONE SPECIMEN (H&E/ADDT'L STAINS AS NEEDED)
☐ INFLAMMATORY CONDITION
☐ TUMOR
☐ ARTHRITIC BONE
☐ LYTIC BONE LESION
☐ OTHER ______

SPECIMEN C

SPECIMEN SITE

CLINICAL IMPRESSION | HISTORY

NAIL SPECIMEN (H&E/PAS)
☐ DYSTROPHY
☐ FUNGUS
☐ PIGMENTED|STREAKED
☐ OTHER ______

SKIN SPECIMEN (H&E/ADDT'L STAINS AS NEEDED)
☐ PIGMENTED (R/O MELANOMA)
☐ CARCINOMA (R/O BCC | SCC)
☐ DERMATITIS (PROVIDE R/O)
☐ VERUCA
☐ ULCERATION (PROVIDE R/O)
☐ OTHER ______

SOFT TISSUE|BONE SPECIMEN (H&E/ADDT'L STAINS AS NEEDED)
☐ INFLAMMATORY CONDITION
☐ TUMOR
☐ ARTHRITIC BONE
☐ LYTIC BONE LESION
☐ OTHER ______

BILLING METHOD / INSURANCE INFORMATION (ITS OK TO ATTACH A COPY OF INSURANCE CARD FRONT/BACK)

BILLING METHOD
○ INSURANCE
○ MEDICARE
○ MEDICAID
○ PATIENT
○ PHYSICIAN

PRIMARY INSURANCE

NSURED NAME / RELATIONSH P TO NSURED: ○ Self ○ Spouse ○ Dependent

NSURANCE NAME

NSURANCE PHONE

NSURANCE ADDRESS

CITY | STATE | Z P CODE

EMPLOYER NAME

SUBSCR BER DOB: / / | MEMBER D# | GROUP/CONTRACT #

MEDICARE # | MEDICA D #

SECONDARY INSURANCE

INSURED NAME / RELATIONSHIP TO NSURED: ○ Self ○ Spouse ○ Dependent

INSURANCE NAME

INSURANCE PHONE

INSURANCE ADDRESS

CITY | STATE | ZIP CODE

EMPLOYER NAME

SUBSCRIBER DOB: / / | MEMBER D# | GROUP/CONTRACT #

MEDICARE # | MEDICA D #