COCKERELL DERMATOPATHOLOGY™

Diagnostic Excellence. Unparalleled Service.™

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DERMATOPATHOLOGY REQUISITION

PATIENT LAST ______ FIRST ______ MI ______ DAYTIME PHONE ( )

ADDRESS STREET/APT.# ______ CITY ______ ST ______ ZIP CODE ______ EMAIL (FOR PATIENT EDUCATION USE ONLY) ______

DOB / / ______ SEX ______ RACE ______ OFFICE: PATIENT ID# ______

DATE COLLECTED / / ○ RUSH ○ DIF

○ PREVIOUS BIOPSY AND DIAGNOSIS ______

CLINICAL INFORMATION

SPECIMEN SITE	BX TYPE	CLINICAL IMPRESSION / HISTORY / ICD-9 CODE	REQUEST	FOR LAB USE ONLY
A	○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		○ MARGINS	
B	○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		○ MARGINS	
C	○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		○ MARGINS	
D	○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		○ MARGINS	
E	○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		○ MARGINS	
F	○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		○ MARGINS	

BILLING METHOD / INSURANCE INFORMATION

BILLING METHOD	PRIMARY INSURANCE	SECONDARY INSURANCE
○ INSURANCE	INSURED NAME / RELATIONSHIP TO INSURED: ○ Self ○ Spouse ○ Dependent	INSURED NAME / RELATIONSHIP TO INSURED: ○ Self ○ Spouse ○ Dependent
○ MEDICARE	INSURANCE NAME	INSURANCE NAME
○ MEDICAID	INSURANCE PHONE	INSURANCE PHONE
○ PATIENT	INSURANCE ADDRESS	INSURANCE ADDRESS
○ PHYSICIAN	CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE
	EMPLOYER NAME	EMPLOYER NAME
	SUBSCRIBER DOB: / / / MEMBER ID# / GROUP/CONTRACT #	SUBSCRIBER DOB: / / / MEMBER ID# / GROUP/CONTRACT #
	MEDICARE # / MEDICAID #	MEDICARE # / MEDICAID #