

RUSH

LAB USE ONLY - GROSS DESCRIPTION

ORDERING PROVIDER - PLEASE SIGN AT THE BOTTOM

Name: _____

Address: _____

Phone: _____ Fax: _____

Copy to Provider A: _____ Fax: _____

Copy to Provider B: _____ Fax: _____

Date Received
Accessioner
Received in: Formalin (F) Michel's (M)

Accession Number

A) F M

B) F M

C) F M

D) F M

PATIENT INFORMATION - PLEASE ATTACH COPY OF INSURANCE CARD/DEMOGRAPHIC SHEET

Patient Name (Last, First, MI): _____

DOB: ____/____/____ Sex: M F

SSN/MRN: _____ Biopsy Date: ____/____/____

Hair and Nail Specimen

Alopecia Nail

Previous Biopsy

Case # _____

ANATOMICAL SITE	CHECK	CLINICAL DESCRIPTION, DIAGNOSIS, ICD-10 CODE
A)	<input type="checkbox"/> Shave <input type="checkbox"/> AK <input type="checkbox"/> Punch <input type="checkbox"/> BCC <input type="checkbox"/> Excision <input type="checkbox"/> DN <input type="checkbox"/> Curettage <input type="checkbox"/> SCC <input type="checkbox"/> Margins <input type="checkbox"/> SK	DIF <input type="checkbox"/>
B)	<input type="checkbox"/> Shave <input type="checkbox"/> AK <input type="checkbox"/> Punch <input type="checkbox"/> BCC <input type="checkbox"/> Excision <input type="checkbox"/> DN <input type="checkbox"/> Curettage <input type="checkbox"/> SCC <input type="checkbox"/> Margins <input type="checkbox"/> SK	DIF <input type="checkbox"/>
C)	<input type="checkbox"/> Shave <input type="checkbox"/> AK <input type="checkbox"/> Punch <input type="checkbox"/> BCC <input type="checkbox"/> Excision <input type="checkbox"/> DN <input type="checkbox"/> Curettage <input type="checkbox"/> SCC <input type="checkbox"/> Margins <input type="checkbox"/> SK	DIF <input type="checkbox"/>
D)	<input type="checkbox"/> Shave <input type="checkbox"/> AK <input type="checkbox"/> Punch <input type="checkbox"/> BCC <input type="checkbox"/> Excision <input type="checkbox"/> DN <input type="checkbox"/> Curettage <input type="checkbox"/> SCC <input type="checkbox"/> Margins <input type="checkbox"/> SK	DIF <input type="checkbox"/>

LAB USE ONLY - PATHOLOGICAL DIAGNOSIS

REQUISITION

ORDERING PROVIDER'S SIGNATURE: X _____