



Associated Pathology Medical Group

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DERMATOPATHOLOGY REQUISITION

PATIENT INFORMATION			CLIENT INFORMATION		
Last Name		First Name	M.I.		
Date of Birth	Sex M F	Date Specimen Taken ____/____/____			
Patient Social Security Number		Patient Phone Number			
Street Address			Apt. #		
City		State	Zip		

SPECIAL HANDLING	
<input type="checkbox"/> Phone	<input type="checkbox"/> Fax (____) _____ <input type="checkbox"/> CC _____ Physician's Signature _____
Patient reference number _____ Address _____	

BILLING INFORMATION Attach copy of all insurance I.D. cards (front and back, please)	
Bill To: <input type="checkbox"/> Patient <input type="checkbox"/> Doctor <input type="checkbox"/> HMO <input type="checkbox"/> Insurance <input type="checkbox"/> Medicare/Medi-Cal # _____	
Subscriber Name _____ Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____	
Insurance Name _____	Address _____ City, State, Zip _____
ID # _____	Group # _____
Subscriber DOB: _____ Subscriber Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Medicare patient reviewed and signed advanced beneficiary notice for non-covered services	

Diagnosis Code(s)

HISTORY AND CLINICAL DIAGNOSIS

SPECIFIC QUESTIONS / INSTRUCTIONS FOR PATHOLOGY LAB
Pathologist to provide written report <input type="checkbox"/>

SPECIMENS	
1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

Additional ancillary studies, such as special staining techniques and marker studies, are performed at the discretion of the pathologist to provide a proper diagnosis, unless otherwise indicated on the requisition.