

Associated Pathology Medical Group

DERMATOPATHOLOGY REQUISITION

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PATIENT INFORMATION			CLIENT INFORMATION
Last Name	First Name	M.I.	
Date of Birth Specimen Date	Sex MRN #		
/ / /	M F		
Patient Social Security Number	Patient Phone Number		
Street Address	Apt	t. #	
City	State Zip		
SPECIAL HANDLING			
○ Phone ○ Fax ()	Occ		Physician's Signature
			Address
BILLING INFORMATION Attach copy of all insurance I.D. cards (front and back, please)			
Bill To: O Patient O Doctor O HMO O Insurance O Medicare/Medi-Cal #			
Subscriber Name			
Insurance Name	Address	elationship t	to Subscriber: O Self O Spouse O Dependent O Other
	Address		
ID#			Group #
Subscriber DOB:			Subscriber Sex: O Male O Female
Diagnosis Code(s)			
HISTORY AND CLINICAL DIAGNOSIS			
SPECIFIC QUESTIONS / INSTRUCTIONS FOR PATHOLOGY LAB			
			Pathologist to provide written report O
		SPECII	MENS
1			5
2			6
3			7
			8
Additional ancilliary 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.			