Associated Pathology Medical Group

APMG

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PODIATRY REQUISITION

PATIENT 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. #

City | State | Zip

CLIENT INFORMATION

Special Handling

☐ Phone ☐ Fax (_____) _____ ☐ CC _____ Physician's Signature _____

BILLING INFORMATION Attach copy of all insurance I.D. cards (front and back, please)

Bill To: ☐ Patient ☐ Doctor ☐ HMO ☐ Insurance ☐ Medicare/Medi-Cal # _____

Subscriber Name — Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

Insurance Name | Address | City, State, Zip

ID # | Group #

Subscriber DOB: | Subscriber Sex: ☐ Male ☐ Female

☐ Medicare patient reviewed and signed advanced beneficiary notice for non-covered services

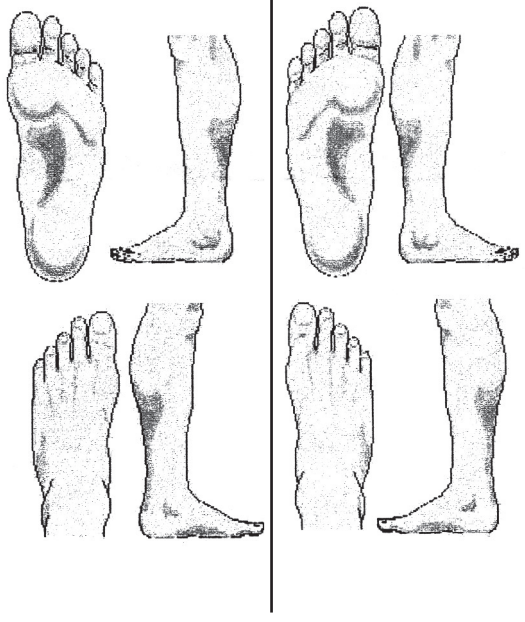
Diagnosis Code(s)

CLINICAL INFORMATION

ANATOMIC SITE/HISTORY/CLINICAL DIAGNOSIS

B = Biopsy E = Excision

	Specimen #1 ☐B ☐E Right	Specimen #1 Left	Specimen #2 ☐B ☐E Right	Specimen #2 Left
SKIN/SOFT TISSUE				
☐ DERMATITIS *(Tinea / "Eczema" / Stasis)*	☐	☐	☐	☐
☐ PIGMENTED LESION *(Nevus / Melanoma / Lentigo)*	☐	☐	☐	☐
☐ TUMOR *(Verruca / Keratosis / Carcinoma)*	☐	☐	☐	☐
☐ ULCER *(Rule out neoplasm)*	☐	☐	☐	☐
☐ OTHER _____	☐	☐	☐	☐
NAIL UNIT				
☐ NAIL DYSTROPHY *(Onychomycosis / Psoriasis / Trauma)*	☐	☐	☐	☐
☐ PAS-Periodic Acid-Schiff (recommended)	☐	☐	☐	☐
☐ Culture and PAS (PAS provides higher sensitivity than KOH)	☐	☐	☐	☐
☐ Culture	☐	☐	☐	☐
☐ ONYCHOCRYPTOSIS	☐	☐	☐	☐
☐ PIGMENTED LESION *(Nevus / Melanoma / Lentigo)*	☐	☐	☐	☐
☐ TUMOR *(Verruca / Keratosis / Carcinoma)*	☐	☐	☐	☐
☐ ULCER *(Rule out neoplasm)*	☐	☐	☐	☐
☐ OTHER _____	☐	☐	☐	☐
BONE				
☐ OSTEOMYELITIS *(Infectious)*	☐	☐	☐	☐
☐ TUMOR *(Cyst / Neoplasm)*	☐	☐	☐	☐
☐ DEGENERATIVE JOINT DISEASE *(Hallux abducto-valgus / Hammer toe)*	☐	☐	☐	☐
☐ OTHER _____	☐	☐	☐	☐



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.

ADDITIONAL CLINICAL INFORMATION