AAD PATHOLOGY

PATHOLOGY REQUISITION

DATE COLLECTED: / /

ACCESSION NUMBER

PHYSICIAN/CLIENT INFORMATION

PATIENT INFORMATION (May use patient identification label)

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		APT. #
CITY	STATE	ZIP CODE
PATIENT PHONE NUMBER	PATIENT SOCIAL SECURITY NUMBER	
DATE OF BIRTH / /	AGE	SEX / PATIENT ID

BILLING / INSURANCE INFORMATION (attach a copy of insurance card - both sides)

BILL:

- ☐ INSURANCE
- ☐ PATIENT
- ☐ MEDICARE
- ☐ MEDICAID
- ☐ PHYSICIAN

SUBSCRIBER PRIMARY INSURANCE

SUBSCRIBER NAME/ RELATIONSHIP TO SUBSCRIBER Self ☐ ☐Spouse ☐Dependent

COMPANY NAME

ADDRESS

CITY | STATE | ZIP CODE

EMPLOYER NAME

SUBSCRIBER DOB: / /	GROUP/CONTRACT#	MEMBER ID #
SUBSCRIBER SEX: ☐Male ☐ Female	MEDICARE #	MEDICAID ID #

SUBSCRIBER SECONDARY INSURANCE

SUBSCRIBER NAME/ RELATIONSHIP TO SUBSCRIBER Self ☐ ☐Spouse ☐Dependent

COMPANY NAME

ADDRESS

CITY | STATE | ZIP CODE

EMPLOYER NAME

SUBSCRIBER DOB: / /	GROUP/CONTRACT#	MEMBER ID #
SUBSCRIBER SEX: ☐Male ☐ Female	MEDICARE #	MEDICAID ID #

PREVIOUS PATHOLOGY ACCESSION#'s:

LAB USE ONLY:

CLINICAL INFORMATION

SITE	CHECK:	GROSS DESCRIPTION	DIAGNOSIS DESCRIPTION
1 PREVIOUS BX ACC #	☐SHAVE ☐PUNCH ☐EXCISION ☐OTHER		
2 PREVIOUS BX ACC #	☐SHAVE ☐PUNCH ☐EXCISION ☐OTHER		
3 PREVIOUS BX ACC #	☐SHAVE ☐PUNCH ☐EXCISION ☐OTHER		
4 PREVIOUS BX ACC #	☐SHAVE ☐PUNCH ☐EXCISION ☐OTHER		
5 PREVIOUS BX ACC #	☐SHAVE ☐PUNCH ☐EXCISION ☐OTHER		
6 PREVIOUS BX ACC #	☐SHAVE ☐PUNCH ☐EXCISION ☐OTHER		

PHYSICIAN'S SIGNATURE X _____ DATE _____

DIFFICULT CASES SOMETIMES REQUIRE ADDITIONAL DIAGNOSTIC STAINS TO ASSIST THE PATHOLOGIST IN MAKING A DEFINITIVE DIAGNOSIS. THE DIAGNOSTIC STAINS MAY RESULT IN ADDITIONAL CHARGES.

FOR LAB USE ONLY

ICD-9 Codes:

Histology: ❑ LS ❑ PR ❑ AH ❑ CA ❑ CC ❑ ME ❑ DN ❑ NM

INTERFACE MARKETING GROUP | 2015