AAD Pathology

Date Collected: _____

Authorizing Provider:

Address:

Accession Number:

PATIENT INFORMATION

Primary Ins: Secondary Ins:			**Please circle one** PPO HMO EPO POS ☐ ☐ ☐ ☐
Primary #	Secondary #		
LAST NAME	FIRST NAME	M.I.	
STREET ADDRESS		APT. #	
CITY	STATE	ZIP CODE	
PATIENT PHONE NUMBER	AGE / SEX	PATIENT SSNO	
ICD-10 CODES	IVF: YES ☐ NO ☐ BEACON YES ☐ NO ☐		

NOTES:

CLINICAL INFORMATION

SITE / CLINICAL INFORMATION / IMPRESSION	CHECK	GROSS DESCRIPTION	DIAGNOSIS DESCRIPTION
1 PREVIOUS BX ACC #	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ MARGINS ☐ CLIPPINGS		
2 PREVIOUS BX ACC #	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ MARGINS ☐ CLIPPINGS		
3 PREVIOUS BX ACC #	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ MARGINS ☐ CLIPPINGS		
4 PREVIOUS BX ACC #	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ MARGINS ☐ CLIPPINGS		
5 PREVIOUS BX ACC #	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ MARGINS ☐ CLIPPINGS		
6 PREVIOUS BX ACC #	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ MARGINS ☐ CLIPPINGS		

FOR PATHOLOGY USE ONLY

88304	88307	88312.26	88331	88344
88304.26	883011	88313	88332	88344.26
88305	88312	88313.26	88341	88346
88305.26				

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