PATHOLOGY REFERENCE LABORATORY, L.L.C.

DERMATOPATHOLOGY REQUISITION

9600 DATAPOINT DR. • SAN ANTONIO, TX 78229
TELE (210) 892-3700 • TOLL FREE (866) 231-8058 • FAX (210) 617-4692

COLLECTION DATE:
____/____/____

BILL TO:
☐ CLIENT
☐ PATIENT
☐ OTHER

ACCOUNT NAME AND ADDRESS

PATIENT LAST NAME | FIRST | M.I.

RELATIONSHIP TO INSURED: ❍ SELF ❍ SPOUSE ❍ DEPENDENT

PHONE ( ) | PATIENT SS # | PATIENT ID/MR # | DATE OF BIRTH / / | SEX ❍ F ❍ M

INSURED NAME/RESPONSIBLE PARTY | INSURED SS #

PATIENT ADDRESS (OR INSUREDRESPONSIBLE PARTY) | APT. NO.

CITY | STATE | ZIP

EMPLOYEE NAME | PHONE ( )

INSURANCE COMPANY NAME

INSURANCE COMPANY ADDRESS

CITY | STATE | ZIP

INSURANCE COMPANY PHONE ( ) | INSURANCE/GROUP # | MEMBER/SUBSCRIBER ID #

MEDICARE # | SUFFIX ❍ PRIMARY ❍ SECONDARY | MEDICAID # | STATE

Send duplicate report to:

Name | Address/Fax

ICD-9 CODE (Required)

Previous Biopsy Number: Previous Biopsy Results:

SPECIMEN NUMBER	SPECIMEN SOURCE / SITE	TYPE SPECIMEN	PRE / POST-OP DIAGNOSIS	MARGINS	CLINICAL HISTORY COMMENTS
(1)		☐ P Bx ☐ Ex ☐ Sh Bx ☐ DIF ☐ Sh Ex		☐ YES ☐ NO	
(2)		☐ P Bx ☐ Ex ☐ Sh Bx ☐ DIF ☐ Sh Ex		☐ YES ☐ NO	
(3)		☐ P Bx ☐ Ex ☐ Sh Bx ☐ DIF ☐ Sh Ex		☐ YES ☐ NO	
(4)		☐ P Bx ☐ Ex ☐ Sh Bx ☐ DIF ☐ Sh Ex		☐ YES ☐ NO	
(5)		☐ P Bx ☐ Ex ☐ Sh Bx ☐ DIF ☐ Sh Ex		☐ YES ☐ NO	
(6)		☐ P Bx ☐ Ex ☐ Sh Bx ☐ DIF ☐ Sh Ex		☐ YES ☐ NO	

COMMENTS: