PATHOLOGY REFERENCE LABORATORY, L.L.C.

PODIATRIC 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

PODIATRIC PATHOLOGY REQUISITION

❑ **LEFT**

❑ **RIGHT**

Previous Tissue . . . . ❑ Yes ❑ No

Date: ______________________

(B) Biopsy or (E) Excision

CLINICAL IMPRESSION	B/E PART 1		B/E PART 2	
❑ **SKIN**				
❑ Pigmented / Melanoma / Nevus	❑	❑	❑	❑
❑ Verruca / Squamous Cell Carcinoma	❑	❑	❑	❑
❑ Dermatitis / Tinea / Psoriasis	❑	❑	❑	❑
❑ Other: ______________	❑	❑	❑	❑
❑ **NAIL**				
❑ Pigmented / Melanoma / Nevus	❑	❑	❑	❑
❑ Dystrophic / Dermatophyte / Psoriasis	❑	❑	❑	❑
❑ PAS (recommended for initial test)	❑	❑	❑	❑
❑ Other: ______________	❑	❑	❑	❑
❑ **SUBCUTANEOUS SOFT TISSUE**				
❑ Neoplastic / Tumor	❑	❑	❑	❑
❑ Inflammatory / Infectious	❑	❑	❑	❑
❑ Other: ______________	❑	❑	❑	❑
❑ **BONE**				
❑ Neoplastic / Tumor	❑	❑	❑	❑
❑ Degenerative Joint Disease	❑	❑	❑	❑
❑ Osteomyelitis	❑	❑	❑	❑
❑ Other: ______________	❑	❑	❑	❑

❑ **MARGINS REQUESTED**

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