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DERMATOPATHOLOGY SPECIMEN REQUISITION

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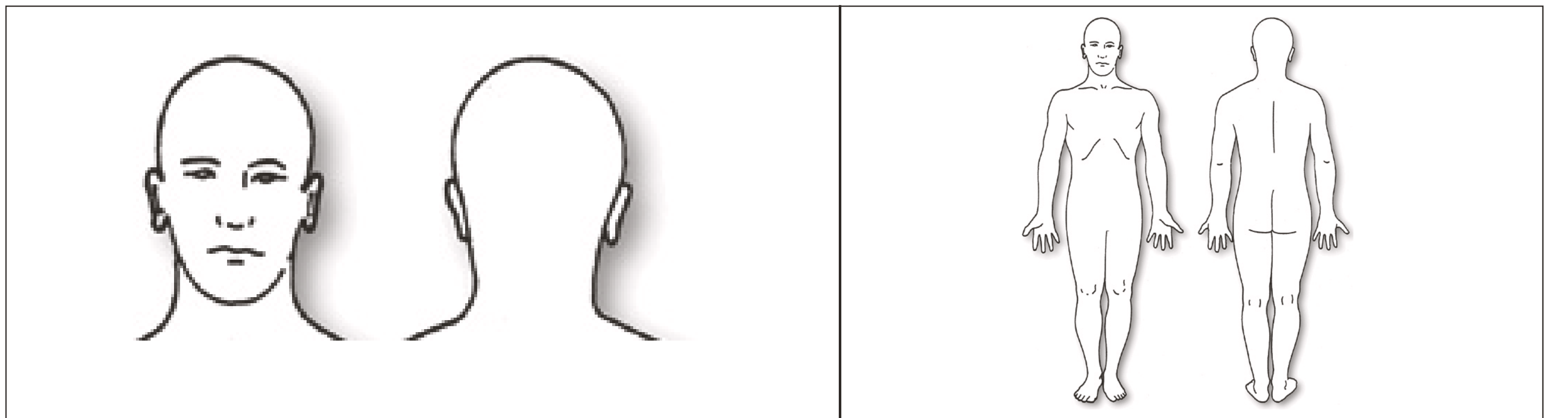
REQUIRED

PATIENT INFORMATION

Last Name	First Name	COLLECTION DATE	COLLECTION TIME

Date of Birth	[ ] Male [ ] Female	**ORDERING PHYSICIAN NAME** (Last, First) **PLEASE PRINT**
Address		**PHYSICIAN OFFICE INFORMATION**
City / State / Zip		
Home Number ( )	Work Number ( )	

BILLING	**ATTACH BOTH SIDES OF ALL INSURANCE CARDS**	**COPIES TO:** NAME / FAX
DIAGNOSIS	**ICD10:**	**COPIES TO:** NAME / FAX



DERMATOPATHOLOGY

SOURCE OF TISSUE		CLINICAL INFORMATION/IMPRESSION
A.	[ ] Shave [ ] Punch [ ] Excision	
B.	[ ] Shave [ ] Punch [ ] Excision	
C.	[ ] Shave [ ] Punch [ ] Excision	
D.	[ ] Shave [ ] Punch [ ] Excision	
E.	[ ] Shave [ ] Punch [ ] Excision	
F.	[ ] Shave [ ] Punch [ ] Excision	

CLINICAL HISTORY