Prepared by:
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DERMATOPATHOLOGY TEST REQUEST FORM

D003L

ANY OMISSION MAY RESULT IN DELAY OF REPORT

PATIENT INFORMATION RACE (optional)

M ☐ F ☐

SS# DATE OF BIRTH

LAST NAME FIRST NAME M.I.

STREET ADDRESS

CITY STATE ZIP

TEL. # CHART # PATH #

PHYSICIAN SIGNATURE_____

DUPLICATE REPORT TO:_____

COMMENTS TO PRINT OUT ON REPORT:_____

CHECK MARGINS ☐ **DATE OBTAINED:**___/___/___

STAT ☐ OTHER_____

CALL MD W/RESULTS ☐ CONSULTATION ☐

BIOPSY METHOD: ☐ PUNCH ☐ EXCISION ☐ INCISIONAL
☐ SHAVE ☐ CURRETTE ☐ SNIP ☐ SAUCERIZATION ☐ LASER

TEST REQUEST:

☐ INCLUDES IHC, SPECIAL (BILLABLE) STAINS, FISH *(Fluorescence in situ hybridization)* AND MOLECULAR TESTING DETERMINED BY PATHOLOGIST

☐ PHYSICIAN MUST BE CONTACTED PRIOR TO PERFORMANCE OF IHC, SPECIAL (BILLABLE) STAINS, FISH OR MOLECULAR TESTING

*** DIF** (DIRECT IMMUNOFLUORESCENSE) CHECK APPROPRIATE BOX
Specimens for DIF testing must be submitted in Michel's fixative media (provided by Acuapth)

☐ PREVIOUS BIOPSY_____

☐ NUMBER OF SPECIMEN BOTTLES_____ ☐ NUMBER OF BLOCKS_____

☐ HPV – TISSUE **If Screen +, do Subtype (6/11, 16/18, 31/33)**

☐ COMPREHENSIVE EVALUATION FOR MELANOMA and SPITZ NEVUS
Acupath dermatopathologists choose all IHC, special (billable) stains and FISH testing for diagnosis under consideration or as deemed medically necessary, unless otherwise indicated by ordering physician in Test Request section above.

INDIVIDUAL FISH PANELS:

☐ ***Acu*Probe™ FISH Panel for Melanoma**

☐ ***Acu*Probe™ HRAS FISH Panel for Spitz Nevus**

☐ COMPREHENSIVE EVALUATION FOR LYMPHOMA
Acupath dermatopathologists choose all IHC, special (billable) stains and molecular testing for diagnosis under consideration or as deemed medically necessary, unless otherwise indicated by ordering physician in Test Request section above.

BIOPSY SITE	*DIF	RPMI FLOW	DURATION / HISTORY / CLINICAL DIAGNOSIS
☐ *Perform Cytospin if necessary*			
A			
B			
C			
D			
E			
F			

BILL TO: ☐ **LABORATORY** ☐ **HOSPITAL** ☐ **OTHER** _____

PATIENT'S PRIMARY INSURANCE

BILL TO: ☐ **MEDICARE** ☐ **PATIENT** ☐ **OTHER** ☐ **NO FAULT** ☐ **WORKERS COMP**

INSURED'S NAME_____ D.O.B.___/___/___

DATE OF ACCIDENT (IF NO FAULT/WORKERS COMP)___/___/___

PT RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

POLICY #_____ SS # _____

GROUP NAME/#_____ **REFERRAL #**_____

NAME OF INSURANCE CO._____

INSURANCE ADDRESS*_____

CITY_____ STATE_____ ZIP_____

***If previous biopsy on file with Acupath and same insurance, please check box ☐**

SECONDARY INSURANCE

INSURED'S NAME_____ D.O.B.___/___/___

PT RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

POLICY #_____ SS # _____

GROUP NAME/#_____ **REFERRAL #**_____

NAME OF INSURANCE CO._____

INSURANCE ADDRESS*_____

CITY_____ STATE_____ ZIP_____

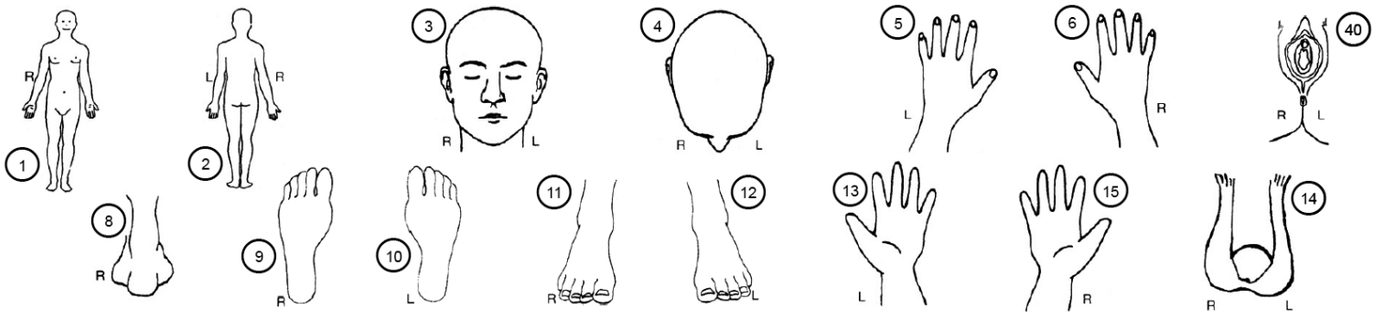
***If previous biopsy on file with Acupath and same insurance, please check box ☐**

I authorize the release to my insurance carrier of any medical information necessary to process this claim, and I authorize payment of medical benefits directly to Acupath Laboratories, Inc. I understand that if I do not have insurance, I will be billed directly by Acupath Laboratories, Inc. I also authorize release of my pathology results to my doctor utilizing all methods of transmission according to HIPAA regulations.

Patient Signature_____

CLINICAL DATA (Required)_____

PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD OR FILL OUT INSURANCE SECTION



BAG

Remove labels and affix to specimen bottles and bag.
(1 label per bottle, 1 label for bag)

A _____ C _____ E _____

B _____ D _____ F _____

SAMPLE