



TEL # 1-888-“ACUPATH” (228-7284)
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 28 S. TERMINAL DRIVE, PLAINVIEW, NY 11803

**PODIATRIC PATHOLOGY
 TEST REQUEST FORM**

P001L

ANY OMISSION MAY RESULT
 IN DELAY OF REPORT

ACUPATH LABORATORIES, INC. WWW.ACUPATH.COM
 “FOR THE ABSOLUTE HIGHEST STANDARD IN PODIATRIC PATHOLOGY” © 2017

PHYSICIAN SIGNATURE
 DUPLICATE REPORT TO:
 COMMENTS TO PRINT OUT ON REPORT:

CHECK MARGINS DATE OBTAINED: / /
 STAT OTHER
 CALL MD W/RESULTS CONSULTATION

COLLECTION METHOD: PUNCH EXCISION AMBIOPUNCTURE
 SHAVE CURETTE SNIP SAUCRIZATION LASER
 FLUID ASPIRATION FOR CRYSTAL IDENTIFICATION (Submit in sterile container)

TEST REQUEST:
 INCLUDES SPECIAL (BILLABLE) STAINS DETERMINED BY PATHOLOGIST
 PHYSICIAN MUST BE CONTACTED PRIOR TO PERFORMANCE OF SPECIAL (BILLABLE) STAINS
 PREVIOUS BIOPSY
 # OF SPECIMEN BOTTLES _____ SLIDES _____ BLOCKS _____

FISH (Fluorescence In Situ Hybridization) TESTING:
 AcuProbe™ Melanoma (for Melanoma confirmation)
 AcuProbe™ Spitz (for Spitz nevus confirmation)

NERVE FIBER DENSITY TESTING

BIOPSY SITE	PAS	DURATION / HISTORY / CLINICAL DIAGNOSIS
A		
B		
C		

CLINICAL DATA (Required):

PATIENT INFORMATION RACE (optional)

SS# DATE OF BIRTH M F

LAST NAME FIRST NAME M.I.

STREET ADDRESS

CITY STATE ZIP

TEL. # CHART # PATH #

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/#

NAME OF INSURANCE CO.

INSURANCE ADDRESS

CITY STATE ZIP

SECONDARY INSURANCE

INSURED'S NAME D.O.B. / /

PT RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

POLICY # SS #

GROUP NAME/#

NAME OF INSURANCE CO.

INSURANCE ADDRESS

CITY STATE ZIP

I authorize the release to my insurance carrier of my 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 _____

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

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

_____	A
_____	B
_____	C
_____	D

