RABKIN DERMATOPATHOLOGY LABORATORY, P.C.

419 E. SECOND AVENUE, TARENTUM, PENNSYLVANIA 15084

(412) 968.9266 (800) 786.3054 FAX (412) 968.5673 www.rabkindermpath.com

REQUEST FOR DERMATOPATHOLOGY SERVICES

Physician's Name (please print or stamp)	Physician's Signature	Office Location (if multiple offices)	Accession # (Lab)
SAMPLE, M.D.	Physician	PGH	
Desired Study ◯ H & E ◯ IF Tissue ◯ Consult ◯ IF Serum	Priority ◯ Normal ◯ Rush Fax #	Date of Surgery 7/10/09	Date Received (Lab)
Patient's Social Security # 123-45-6789	Patient's First Name SAMPLE	Patient's Last Name PATIENT	

Clinical History / Clinical Diagnosis

1.) MOLE - LEFT LEG

2.) ATYPICAL NEVUS - ABDOMEN

Patient's Address - Street	City	State	Zip	
11 MELODY LANE	PITTSBURGH	PA	15000	◯ This patient lives in a skilled nursing facility, hospital or hospice.

Patient's Telephone Number	Date of Birth	Sex	Race	Physician's Office File #
Work (Home) 412.123-4567	11/13/54	M	☒ W ◯ B Other ______	

cc Report To:

INSURANCE INFORMATION (OR please attach photocopies of patient's insurance cards)

Name of Primary Insurance Company	Policy #	Group # or Employer Name
BLUE SHIELD of PA	ABC123456789	ABC123
Name of Subscriber (Required if patient is not subscriber)	Relationship of Patient to Subscriber (if not self) ◯ Spouse ◯ Child ◯ Other	

Name of Secondary Insurance Company	Policy #	Group # or Employer Name
Name of Subscriber (Required if patient is not subscriber)	Relationship of Patient to Subscriber (if not self) ◯ Spouse ◯ Child ◯ Other	

Specimen # 1 Location: LEFT LEG
☒ Punch 4 mm ◯ Shave ◯ Snip ◯ Curettings
◯ Excision Without Margins ◯ Excision With Margins

Specimen # 2 Location: ABDOMEN
◯ Punch ____ mm ◯ Shave ◯ Snip ◯ Curettings
◯ Excision Without Margins ☒ Excision With Margins

Specimen # 3 Location:
◯ Punch ____ mm ◯ Shave ◯ Snip ◯ Curettings
◯ Excision Without Margins ◯ Excision With Margins

Specimen # 4 Location:
◯ Punch ____ mm ◯ Shave ◯ Snip ◯ Curettings
◯ Excision Without Margins ◯ Excision With Margins

GROSS DESCRIPTION - Laboratory Use Only

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☒ FRONT ◯ REAR

INFORMATION AND PAYMENT RELEASE — PATIENT SIGNATURE REQUIRED

I authorize any holder of medical or other information about me to release to the Social Security Administration Health Care Financing Administration or its intermediaries or carriers or to any other insurance carrier or to the billing agent of this physician which is Rabkin Dermatopathology Laboratory, P.C. any information which is needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts this assignment.

Front sheet is laboratory copy. Last sheet may be retained for physician's records.

Sample Patient 7/10/09

PATIENT'S SIGNATURE DATE