



# RABKIN DERMATOPATHOLOGY LABORATORY, P.C.

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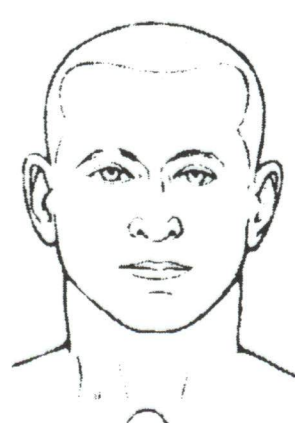
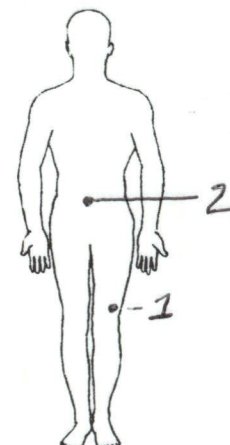
www.rabkindermopath.com



## REQUEST FOR DERMATOPATHOLOGY SERVICES

Physician's Name (please print or stamp) <b>SAMPLE, M.D.</b>		Physician's Signature <b>Physician</b>		Office Location (if multiple offices) <b>PGH</b>		Accession # (Lab)	
Desired Study <input type="radio"/> H & E <input type="radio"/> IF Tissue <input type="radio"/> Consult <input type="radio"/> IF Serum		Priority <input type="radio"/> Normal <input type="radio"/> Rush		Date of Surgery <b>7/10/09</b>		Date Received (Lab)	
Patient's Social Security # <b>123-45-6789</b>		Patient's First Name <b>SAMPLE</b>		Patient's Last Name <b>PATIENT</b>			
Clinical History / Clinical Diagnosis <b>1.) MOLE - LEFT LEG</b> <b>2.) ATYPICAL NEVUS - ABDOMEN</b>							
Patient's Address - Street <b>11 MELODY LANE</b>			City <b>PITTSBURGH</b>		State <b>PA</b>	Zip <b>15000</b>	<input type="radio"/> This patient lives in a skilled nursing facility, hospital or hospice.
Patient's Telephone Number Work Home <b>412-123-4567</b>		Date of Birth <b>11/13/54</b>		Sex <b>M</b>	Race <input checked="" type="radio"/> W <input type="radio"/> B Other _____	Physician's Office File #	

INSURANCE INFORMATION (OR please attach photocopies of patient's insurance cards)			cc Report To:	
Name of Primary Insurance Company <b>BLUE SHIELD of PA</b>		Policy # <b>ABC123456789</b>		Group # or Employer Name <b>ABC123</b>
Name of Subscriber (Required if patient is not subscriber)		Relationship of Patient to Subscriber (if not self) <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> 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) <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other		

<b>Specimen # 1 Location: LEFT LEG</b> <input checked="" type="radio"/> Punch <b>4</b> mm <input type="radio"/> Shave <input type="radio"/> Snip <input type="radio"/> Curettings <input type="radio"/> Excision Without Margins <input type="radio"/> Excision With Margins		 
<b>Specimen # 2 Location: ABDOMEN</b> <input type="radio"/> Punch ___ mm <input type="radio"/> Shave <input type="radio"/> Snip <input type="radio"/> Curettings <input type="radio"/> Excision Without Margins <input checked="" type="radio"/> Excision With Margins		
<b>Specimen # 3 Location:</b> <input type="radio"/> Punch ___ mm <input type="radio"/> Shave <input type="radio"/> Snip <input type="radio"/> Curettings <input type="radio"/> Excision Without Margins <input type="radio"/> Excision With Margins		
<b>Specimen # 4 Location:</b> <input type="radio"/> Punch ___ mm <input type="radio"/> Shave <input type="radio"/> Snip <input type="radio"/> Curettings <input type="radio"/> Excision Without Margins <input type="radio"/> Excision With Margins		
GROSS DESCRIPTION - Laboratory Use Only		

**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.

**Sample Patient** 7/10/09  
 PATIENT'S SIGNATURE DATE

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