RABKIN DERMATOPATHOLOGY LABORATORY, P.C.

440 William Pitt Way, Pittsburgh, PA 15238

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REQUEST FOR DERMATOPATHOLOGY SERVICES

Physician's Name (please print or stamp)	Physician's Signature	Office Location (if multiple offices)	Accession # (Lab)
Desired Study ○ H & E ○ IF Tissue ○ Consult ○ IF Serum	Priority ○ Normal ○ Rush Fax #	Date of Surgery	Date Received (Lab)
Patient's Social Security #	Patient's First Name	Patient's Last Name	

Clinical History / Clinical Diagnosis

Patient's Address - Street	City	State	Zip	○ This patient lives in a skilled nursing facility, hospital or hospice.

Patient's Telephone Number Work Home	Date of Birth	Sex	Race ○ W ○ 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	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	
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	

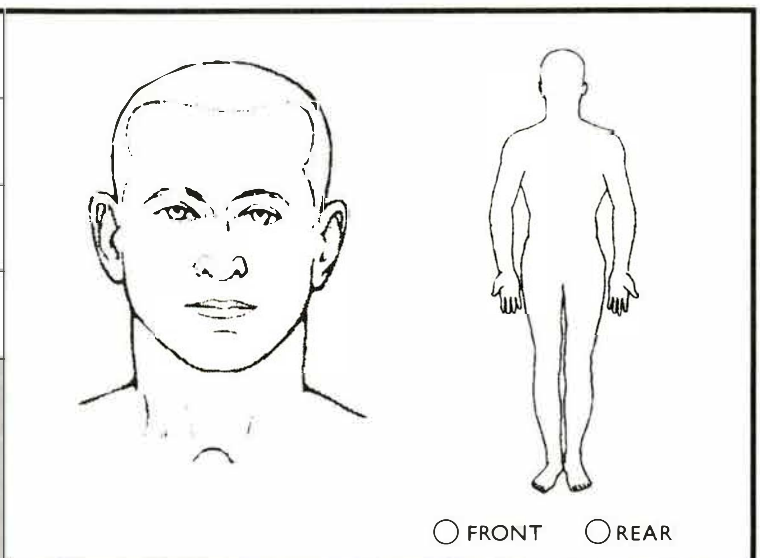
Specimen # 1 Location:
○ Punch ____ mm ○ Shave ○ Snip ○ Curettings
○ Excision Without Margins ○ Excision With Margins

Specimen # 2 Location:
○ 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



○ 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.

PATIENT'S SIGNATURE DATE