DERMATOPATHOLOGY REQUISITION

RABKIN Dermatopathology Laboratory, P.C.

☐ ROUTINE INTERPRETATION ☐ SLIDE PREP ☐ CONSULTATION

NAIL: ☐ PAS ☐ IMMUNOFLUORESCENCE

☐ FROZEN SECTION
☐ RUSH

DATE COLLECTED ____/____/____

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		APT. #
CITY	STATE	ZIP CODE
PATIENT PHONE NUMBER	MRN	
DATE OF BIRTH / /	SEX	PATIENT AGE

PHYSICIAN INFORMATION

BILLING / INSURANCE

BILL:

☐ INSURANCE

☐ PATIENT

☐ **NURSING HOME PT.**

PRIMARY INSURANCE (attach a copy of insurance card - both sides)

INSURED NAME / RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

INSURED'S DATE OF BIRTH / / | INSURED'S SEX: ☐ Male ☐ Female

INSURANCE COMPANY NAME - ADDRESS

CITY | STATE | ZIP CODE

EMPLOYER NAME

GROUP/CONTRACT # | MEMBER ID#

SECONDARY INSURANCE (attach a copy of insurance card - both sides)

INSURED NAME / RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

INSURED'S DATE OF BIRTH / / | INSURED'S SEX: ☐ Male ☐ Female

INSURANCE COMPANY NAME - ADDRESS

CITY | STATE | ZIP CODE

EMPLOYER NAME

GROUP/CONTRACT # | MEMBER ID#

PLEASE ATTACH COPY OF INSURANCE CARDS

CLINICAL INFORMATION

SITE	CHECK:	MARGINS?	CLINICAL DIAGNOSIS AND HISTORY
1	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
2	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
3	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
4	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
5	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
6	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	

PHYSICIAN'S SIGNATURE (Required in NY, NJ, MA, PA and WV) X _____ **DATE** _____

In some cases, additional diagnostic stains may be required for proper evaluation as deemed appropriate by the Rabkin Dermatopathologists. These additional tests may result in additional charges.

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RABKIN LAB (Rev. 6.18)