



SM

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



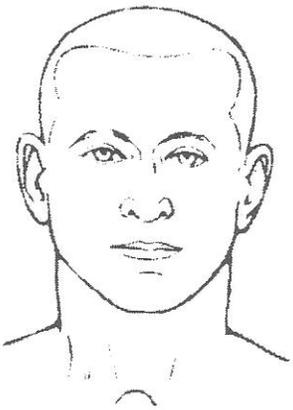
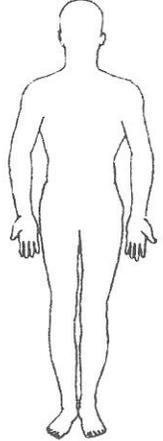
REQUEST FOR DERMATOPATHOLOGY SERVICES

Physician's Name (please print or stamp)		Physician's Signature		Office Location (if multiple offices)		Accession # (Lab)	
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 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	<input type="radio"/> This patient lives in a skilled nursing facility, hospital or hospice.
Patient's Telephone Number Work Home		Date of Birth	Sex	Race <input 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		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			
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			

Specimen # 1 Location: <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	 
Specimen # 2 Location: <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	
Specimen # 3 Location: <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	
Specimen # 4 Location: <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	

 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 _____