



SM

SAMPLE

RABKIN DERMATOPATHOLOGY LABORATORY, P.C.

419 E. SECOND AVENUE, TARENTUM, PENNSYLVANIA 15084

(412) 968.9266

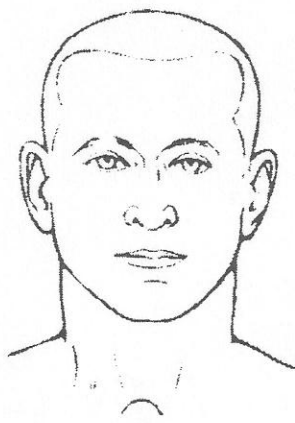
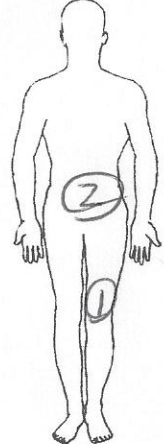
(800) 786.3054

FAX (412) 968.5673

www.rabkindermpath.com

**REQUEST FOR DERMATOPATHOLOGY SERVICES**

Physician's Name (please print or stamp) Sample	Physician's Signature Physican	Office Location (if multiple offices) PGH	Accession # (Lab)
Desired Study <input checked="" type="checkbox"/> H & E <input type="checkbox"/> IF Tissue <input type="checkbox"/> Consult <input type="checkbox"/> IF Serum	Priority <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Rush Fax #	Date of Surgery 7-9-12	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 11 Melody Lane	City Pittsburgh	State PA	Zip 15000
Patient's Telephone Number Work Home 412-123-4567	Date of Birth 11-13-1954	Sex M	Race <input checked="" type="checkbox"/> W <input type="checkbox"/> B Other _____
INSURANCE INFORMATION (OR please attach photocopies of patient's insurance cards)			<input type="checkbox"/> This patient lives in a skilled nursing facility, hospital or hospice.
Name of Primary Insurance Company Blue Shield of PA		Policy # ABC 123-45-6789	Group # or Employer Name ABC 123
Name of Subscriber (Required if patient is not subscriber)		Relationship of Patient to Subscriber (if not self) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
cc Report To:			

Specimen # 1 Location: LEFT LEG <input checked="" type="checkbox"/> Punch <u>4</u> mm <input type="checkbox"/> Shave <input type="checkbox"/> Snip <input type="checkbox"/> Curettings <input type="checkbox"/> Excision Without Margins <input type="checkbox"/> Excision With Margins	 
Specimen # 2 Location: Abdomen <input type="checkbox"/> Punch ___ mm <input type="checkbox"/> Shave <input type="checkbox"/> Snip <input type="checkbox"/> Curettings <input type="checkbox"/> Excision Without Margins <input checked="" type="checkbox"/> Excision With Margins	
Specimen # 3 Location: <input type="checkbox"/> Punch ___ mm <input type="checkbox"/> Shave <input type="checkbox"/> Snip <input type="checkbox"/> Curettings <input type="checkbox"/> Excision Without Margins <input type="checkbox"/> Excision With Margins	
Specimen # 4 Location: <input type="checkbox"/> Punch ___ mm <input type="checkbox"/> Shave <input type="checkbox"/> Snip <input type="checkbox"/> Curettings <input type="checkbox"/> Excision Without Margins <input type="checkbox"/> Excision With Margins	
GROSS DESCRIPTION - Laboratory Use Only	
<input checked="" type="checkbox"/> FRONT <input type="checkbox"/> 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
PATIENT'S SIGNATURE

7-9-2012
DATE