PLEASE PRINT	H DIAGNOSTICS®	Accession #: (Lab Use Only)		
	ATHOLOGY LABORATORY			
(412) 68	• Third Floor • Pittsburgh, PA 15213 2-3083 • (800) 845-3573 12) 682-3511 (fax)			
	, M.D. • John D. Miedler, M.D. D. • Trent B. Marburger, M.D.			I I I I
LAST NAME	RMATION (PLEASE PRINT) FIRST NAME M.I.			I I I I
STREET ADDRESS CITY	APT.# STATE ZIP			i !
SOCIAL SECURITY #		_		
LAST 4 DIGITS REQUIRED DATE OF BIRTH REQUIRED PATIENT'S PHONE NUMBER	SEX RACE	If information is missing, conflicting, or in client to obtain and/or clarify this information	ncomplete, a call to the ation will be documented.	
	BILLING I	INFORMATION		
		RD(S) - BOTH SIDES - OR COMPLETE		
COMPANY NAME:	IMARY INSURANCE ————————————————————————————————————	COMPANY NAME: SECONDARY INSI	UKANCE ————	1
ADDRESS:		ADDRESS:		
CITY:	STATE: ZIP CODE:	CITY: STATE:	ZIP CODE:	
NAME OF POLICY HOLDER:		NAME OF POLICY HOLDER:		
RELATIONSHIP TO INSURED: SELF POLICY #:	SPOUSE CHILD SUBSCRIBER DOB	RELATIONSHIP TO INSURED: SELF SPOUSE POLICY #:	CHILD SUBSCRIBER DOB	
GROUP/CONTACT #:	SUBSCRIBER DUB SUBSCRIBER SEX	GROUP/CONTACT #:	SUBSCRIBER DUB SUBSCRIBER SEX	
GNUUT/CUNTACT#.	□ MALE □ FEMALE CLINICAL INFORMATION		☐ MALE ☐ FEMALE	
DATE COLLECTED:/_		VIOUS Bx? ☐ No ☐ Yes CASE#		
SITE	PLEASE CHECK: MARGINS?	CLINICAL DIAGNOSIS & HISTORY	GROSS	
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER		(Lab Use Only)	
D)	SHAVE PUNCH EXCISION			
<u> </u>	☐ OTHER ☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER			
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER			
☐ ROUTINE HISTOLOGY		SUMMARY IMMUNOFLUORESCENCE		
	Fungal; Bacterial		Cell markers	
PHYSICIAN'S SIGNATURE SIGNATURE	(Required in NY, NJ, MA, PA and WV)	DATE:		
Difficult cases sometimes require add	itional diagnostic stains to assist the dermatopatholo	ogist in making a definitive diagnosis. These diagnostic st		' ' ! !
SPECIMEN CONTAINER M	IUST CUNTAIN PATIENT NAME AND	J SITE PHYSICIAN	DPL-125-0002 (Rev. 6/14)	

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Mandi P. Sachdeva	.12) 682-3511 (fax) n, M.D. • John D. Miedler, M.D. D. • Trent B. Marburger, M.D.		
PATIENT INFO	RMATION (PLEASE PRINT) FIRST NAME M.I.		
EET ADDRESS	APT. # STATE ZIP		
IAL SECURITY #	SIAIL ZII	_	
AST 4 DIGITS REQUIRED OF BIRTH COUIRED ENT'S PHONE NUMBER	SEX RACE	If information is missing, conflicting, or client to obtain and/or clarify this inform	incomplete, a call to the nation will be documented.
ATT		NFORMATION	- PELOW
	RIMARY INSURANCE —	D(S) - BOTH SIDES - OR COMPLETE COMPANY NAME: SECONDARY IN	
RESS:		ADDRESS:	
	STATE: ZIP CODE:	CITY: STATE:	ZIP CODE:
IE OF POLICY HOLDER: TIONSHIP TO INSURED:		NAME OF POLICY HOLDER: RELATIONSHIP TO INSURED:	
	SPOUSE CHILD SUBSCRIBER DOB	□ SELF □ SPOUSE POLICY#:	CHILD SUBSCRIBER DOB
UP/CONTACT #:	SUBSCRIBER SEX	GROUP/CONTACT #:	SUBSCRIBER SEX
TE COLLECTED /	CLINICAL INFORMATIO		
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	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER		(Lab Use Only)
D D	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER		
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER		
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER		
		SUMMARY	
ROUTINE HISTOLOGY	Fungal; Bacterial	☐ IMMUNOFLUORESCENCE Direct; Serum (Indirect); _	Cell markers
IYSICIAN'S SIGNATURE	(Required in NY, NJ, MA, PA and WV)		
GNATURE		DATE:	

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ATT		NFORMATION	- PELOW
	RIMARY INSURANCE —	D(S) - BOTH SIDES - OR COMPLETE COMPANY NAME: SECONDARY IN	
RESS:		ADDRESS:	
	STATE: ZIP CODE:	CITY: STATE:	ZIP CODE:
IE OF POLICY HOLDER: TIONSHIP TO INSURED:		NAME OF POLICY HOLDER: RELATIONSHIP TO INSURED:	
	SPOUSE CHILD SUBSCRIBER DOB	□ SELF □ SPOUSE POLICY#:	CHILD SUBSCRIBER DOB
UP/CONTACT #:	SUBSCRIBER SEX	GROUP/CONTACT #:	SUBSCRIBER SEX
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	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER		(Lab Use Only)
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	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER		
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GNATURE		DATE:	