DERMPATH DIAGNOSTICS®
TROY AND ASSOCIATES

DERMATOPATHOLOGY REQUISITION

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☐ ROUTINE INTERPRETATION ☐ SLIDE PREP ☐ CONSULTATION

DATE COLLECTED ____/____/____ ☐ IMMUNOFLUORESCENCE NAIL: ☐ PAS ☐ FUNGAL CULTURE

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
☐ MEDICARE
☐ MEDICAID
☐ PHYSICIAN

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

PATIENT'S SIGNATURE X **DATE**

CLINICAL INFORMATION

SITE	CHECK:	MARGINS?	CLINICAL DIAGNOSIS AND HISTORY
A	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
B	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
C	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
D	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
E	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	
F	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER	☐	

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

FOR LAB USE ONLY

ICD-9 Codes:

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