

DATE OF SERVICE:



SPECIAL REQUEST:

☐ RUSH

☐ Other _____

Submitting Clinician:

Comments or CC (please provide fax # for cc):

PATIENT DEMOGRAPHICS & BILLING INFORMATION

First Name	Last Name	MI	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
			DOB: — —
Street Address: _____			
City: _____		State: _____	Zip: _____
Phone number: _____		Additional info: _____	
<input type="checkbox"/> Bill insurance [Please attach copies of both sides of insurance card(s)]		<input type="checkbox"/> Bill other [Please specify] _____	
<input type="checkbox"/> Bill patient/Self-pay [Please provide complete patient demographic information]		<input type="checkbox"/> Insurance verified, on file at Tiaga Pathology	

SPECIMENS

Anatomic Site

Specimen type, Clinical history & Clinical findings:

A.	Shave/ ____mm Punch/ Snip/ Clip/ Scallop bx/ Incisional bx/ Excision/ Re-excision
B.	Shave/ ____mm Punch/ Snip/ Clip/ Scallop bx/ Incisional bx/ Excision/ Re-excision
C.	Shave/ ____mm Punch/ Snip/ Clip/ Scallop bx/ Incisional bx/ Excision/ Re-excision
D.	Shave/ ____mm Punch/ Snip/ Clip/ Scallop bx/ Incisional bx/ Excision/ Re-excision

Physician signature

Date

Laboratory use only:

Accession #: