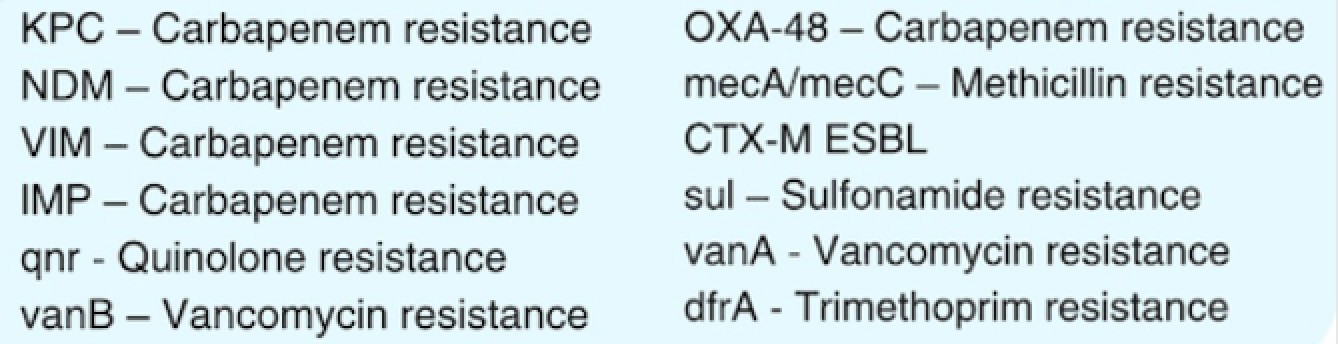
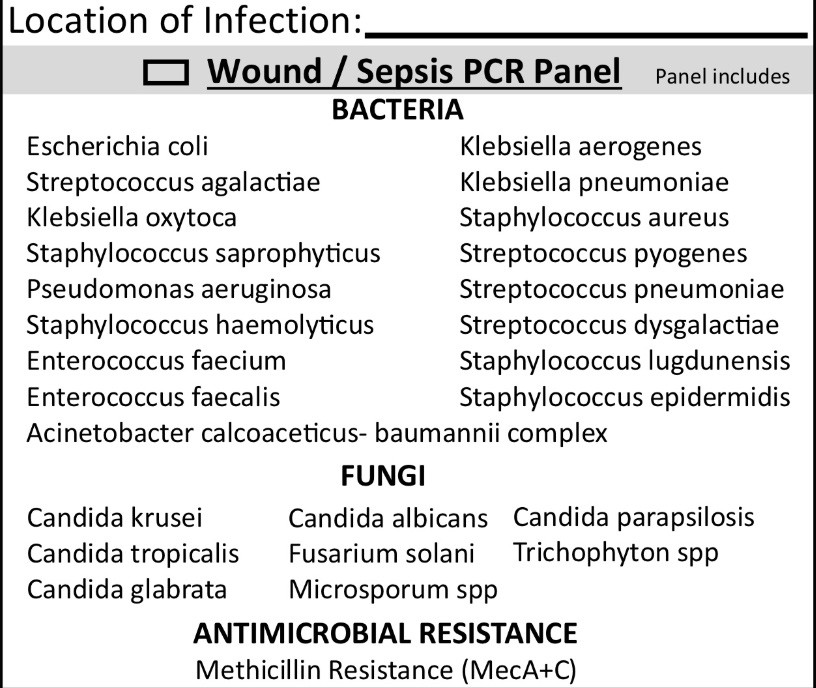
North West Labs

**Billing Information (Please include a copy of the front & back of card.)**



**Biopsy Information**

Antimicrobial Resistance Panel

|  |  |  |
| --- | --- | --- |
| Billing Type: □ Patient □ Insurance □ Client Relation (Req | | uired): □Self □Spouse □Dependant Insured’s Name (if |
| not patient): | | |
| Insured’s SS#: | | Insured’s DOB: |
| Primary Insurance Carrier: | Medicare, Medicaid or Policy ID#: | |
| Claims Address: | | |
| Employer/Group Name: | Group#: | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ICD10 codes (required):`** | | | | |
| Date Collected Req.): ( | | Time Collected: Collector Si | gnature: No. vials collected: |  |
| Type: D Punch Biopsy D D Shave Removal (Ink) DAlopecia Sections Punch Excision (Ink) D D Excision (Ink) D DIF D  Shave Biopsy Currettage | | | | |
| **1** Site:  **Clinical Findings**  D Nevus Atypical D SCC D FEP  D Melanoma DBCC D AK D DF  D SK DVV | | | | |
| **2** Site:  **Clinical Findings**  D Nevus Atypical D SCC D FEP  D Melanoma D AK D DF  D BCC D SK DVV | | | | |
| **3** Site: |  | | | |
| **Clinical Findings**  D Nevus Atypical D SCC D FEP  D Melanoma D AK D DF  D BCC D SK DVV | | | | |
| 1401 Biopsy (H&E Stain)  1499 Nail with Nail Bed Biopsy with PAS | | | | |

29580 Northwestern Hwy,

Southfield, MI 48034

(248) 301-6917

Dermatology Test Requisition Form

**Patient Information (Please Print)**

**Sexual Orientation:** □Bisexual □Straight □Gay or Lesbian □Something else □ Does not wish to disclose □ Not provided □ Not applicable

**Gender Identity:** □Male □ Female □Gender nonconforming □Transgender male-to-female

□Transgender female-to-male □ Does not wish to disclose □Not provided □ Not applicable

**Ethnicity:** □ Hispanic or Latino

* Not Hispanic or Latino
* Unknown

**Race:** □Alaska Native or American Indian □Asian □ Black or African American □ Multiracial □ Native Hawaiian or other Pacific Islander

* Other race □ White □ Does not wish to disclose □Not provided
* Cell Phone
* Home Phone

Phone Number:

Patient ID#:

Date of Birth (Required):

Assigned Sex at Birth (Required):

□Female □Male

Zip:

State:

City:

Patient Address:

In Care of:

Name (Last, First) (Required):

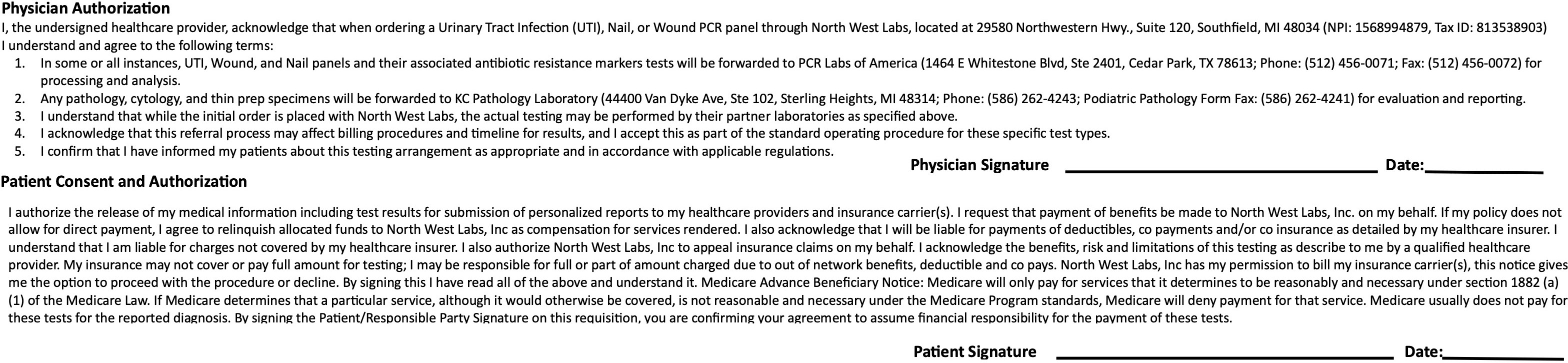
**Ordering Physician/Laboratory**

Date:

Physician’s Signature:

Physician to receive additional result report:

(Required: Include the ordering physician’s first & last name, NPI, practice name, complete address, phone number and fax number.)



**Other Tests/Panels:**

**ICD10 codes (required):**