Cleveland Clinic Laboratories

**Deliver to Surgical Pathology**
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

☐ STAT

# DERMATOPATHOLOGY REQUISITION

<<FORM_ID>>

## PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date | Sex ☐ M ☐ F

City | SS #

State | Zip | Home Phone

MRN/Hospital/Physician Office Patient ID # | Accession/Case #

## CLIENT INFORMATION

MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

## INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

**BILL TO:** ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

**PATIENT STATUS:** ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: _____/_____/_____

**PRIMARY:** ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

**SECONDARY:** ☐ No ☐ Yes (if Yes, please attach)

## ORDERING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

Date Collected: _____/_____/_____

Collected By: _____

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

**DIAGNOSIS CODE (REQUIRED)** ICD-10 Codes 1. _____ 2. _____ 3. _____

**Test Performed: Gross examination and diagnostic interpretation**

## SPECIMEN A

Biopsy Site: _____

Collection Date: _____

Collection Time: _____

Type of Fixative:
☐ Alcohol
☐ Fresh tissue
☐ Formalin
☐ Michel's

Date in Fixative: _____

Time in Fixative: _____

Check off appropriate type of biopsy:
☐ Punch
☐ Punch Excision
☐ Shave
☐ Shave Excision
☐ Curettings
☐ Excision
☐ Wide Excision
Margins: ☐ Yes ☐ No

Additional Tests:
☐ Direct Immunofluorescense
☐ Immunohistochemistry
Stain: _____
☐ Melanoma FISH
☐ BRAF V600
☐ T-Cell Clonality (*TCRB* and *TCRG*)
☐ B-Cell Clonality (*IGH* and *IGK*)
☐ Other: _____

Clinical History: _____

## SPECIMEN B

Biopsy Site: _____

Collection Date: _____

Collection Time: _____

Type of Fixative:
☐ Alcohol
☐ Fresh tissue
☐ Formalin
☐ Michel's

Date in Fixative: _____

Time in Fixative: _____

Check off appropriate type of biopsy:
☐ Punch
☐ Punch Excision
☐ Shave
☐ Shave Excision
☐ Curettings
☐ Excision
☐ Wide Excision
Margins: ☐ Yes ☐ No

Additional Tests:
☐ Direct Immunofluorescense
☐ Immunohistochemistry
Stain: _____
☐ Melanoma FISH
☐ BRAF V600
☐ T-Cell Clonality (*TCRB* and *TCRG*)
☐ B-Cell Clonality (*IGH* and *IGK*)
☐ Other: _____

Clinical History: _____

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