ACUPATH LABORATORIES, INC
TEL # 1-888-"ACUPATH" (228-7284)
TEL # (516) 775-8103
FAX # (516) 326-3452
28 S. TERMINAL DRIVE, PLAINVIEW, NY 11803
WWW.ACUPATH.COM

DERMATOPATHOLOGY TEST REQUEST FORM

V72019

D003BL_TC_17221

ANY OMISSION MAY RESULT IN DELAY OF REPORT

☐ TC ☐ GLOBAL

PHYSICIAN SIGNATURE _____

DUPLICATE REPORT TO: _____

COMMENTS TO PRINT OUT ON REPORT: _____

☐ CHECK MARGINS **DATE OBTAINED:** ___/___/___

☐ **STAT** OTHER_____

☐ CALL MD W/RESULTS ☐ CONSULTATION

ICD-10 CODES

PATIENT INFORMATION RACE (optional)

SS# + + DATE OF BIRTH M ☐ F ☐

LAST NAME FIRST NAME M.I.

STREET ADDRESS

CITY STATE ZIP

TEL. # CHART # PATH #

PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD OR FILL OUT INSURANCE SECTION BELOW

PATIENT'S PRIMARY INSURANCE

BILL TO: ☐ MEDICARE ☐ PATIENT ☐ OTHER ☐ NO FAULT ☐ WORKERS COMP

INSURED'S NAME_____ D.O.B.___/___/___

DATE OF ACCIDENT (IF NO FAULT/WORKERS COMP)___/___/___

PT RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

POLICY #_____ SS# _____

GROUP NAME/#_____

NAME OF INSURANCE CO._____

INSURANCE ADDRESS _____

CITY _____ STATE_____ ZIP_____

SECONDARY INSURANCE

INSURED'S NAME_____ D.O.B.___/___/___

DATE OF ACCIDENT (IF NO FAULT/WORKERS COMP)___/___/___

PT RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

POLICY #_____ SS# _____

GROUP NAME/#_____

NAME OF INSURANCE CO._____

INSURANCE ADDRESS _____

CITY _____ STATE_____ ZIP_____

I authorize the release to my insurance carrier of any medical information necessary to process this claim, and I authorize payment of medical benefits directly to Acupath Laboratories, Inc. I understand that if I do not have insurance, I will be billed directly by Acupath Laboratories, Inc. I also authorize release of my pathology results to my doctor utilizing all methods of transmission according to HIPAA regulations.

Patient Signature_____

BIOPSY METHOD: ☐ PUNCH ☐ EXCISION ☐ INCISIONAL
☐ SHAVE ☐ CURETTE ☐ SNIP ☐ SAUCERIZATION ☐ LASER

TEST REQUEST:

☐ # OF SPECIMEN BOTTLES* _____ SLIDES* _____ BLOCKS* _____

* INCLUDES IHC, SPECIAL (BILLABLE) STAINS, FISH *(Fluorescence in situ hybridization)* AND MOLECULAR TESTING DETERMINED BY PATHOLOGIST

DIF (DIRECT IMMUNOFLUORESCENCE) CHECK APPROPRIATE BOX
Specimens for DIF testing must be submitted in Michel's fixative media (provided by Acupath)

☐ ***Acu*Probe™ MELANOMA COMPREHENSIVE EVALUATION**

Acupath dermatopathologists choose all IHC, special (billable) stains and FISH testing for diagnosis under consideration (Melanoma or Spitz Nevus) or as deemed medically necessary, unless otherwise indicated by ordering physician in Test Request section above.

INDIVIDUAL FISH PANELS:

☐ ***Acu*Probe™ Melanoma** ☐ ***Acu*Probe™ Spitz**

MOLECULAR TESTING:

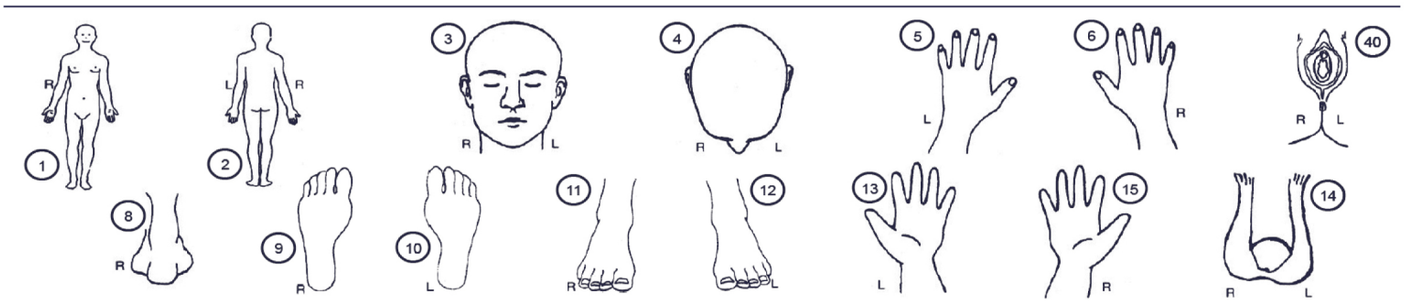
☐ **HPV - TISSUE** ***If Screen Positive, Subtypes (6/11, 16/18, 31-33) are performed***

☐ **COMPREHENSIVE EVALUATION FOR LYMPHOMA**

Acupath dermatopathologists choose all IHC, special (billable) stains and molecular testing for diagnosis under consideration or as deemed medically necessary, unless otherwise indicated by ordering physician in Test Request section above.

BIOPSY SITE	DIF	RPMI FLOW	DURATION / HISTORY / CLINICAL DIAGNOSIS	COMMENTS
☐ *Perform Cytospin if necessary*				
A				
B				
C				
D				
E				
F				

CLINICAL DATA (Required)_____



Remove labels and affix to specimen bottles.
(1 label per bottle)

LABORATORY COPY