ACUPATH LABORATORIES, INC
TEL # 1-888-"ACUPATH" (228-7284)
TEL # (516) 775-8103
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28 S. TERMINAL DRIVE, PLAINVIEW, NY 11803
WWW.ACUPATH.COM
"FOR THE ABSOLUTE HIGHEST STANDARD IN PODIATRIC PATHOLOGY"

PODIATRIC PATHOLOGY TEST REQUEST FORM

P001L

ANY OMISSION MAY RESULT IN DELAY OF REPORT

PHYSICIAN SIGNATURE _____

DUPLICATE REPORT TO: _____

_____

COMMENTS TO PRINT OUT ON REPORT: _____

_____

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

STAT ☐ OTHER _____

CALL MD W/RESULTS ☐ CONSULTATION ☐

COLLECTION METHOD: ☐ PUNCH ☐ EXCISION ☐ INCISIONAL
☐ SHAVE ☐ CURETTE ☐ SNIP ☐ SAUCERIZATION ☐ LASER
☐ FLUID ASPIRATION FOR CRYSTAL IDENTIFICATION (Submit in sterile container)

TEST REQUEST:

☐ INCLUDES SPECIAL (BILLABLE) STAINS DETERMINED BY PATHOLOGIST

☐ PHYSICIAN MUST BE CONTACTED PRIOR TO PERFORMANCE OF SPECIAL (BILLABLE) STAINS

☐ PREVIOUS BIOPSY _____

☐ # OF SPECIMEN BOTTLES _____ SLIDES _____ BLOCKS _____

FISH (Fluorescence In Situ Hybridization) TESTING:

☐ *Acu*Probe™ **Melanoma** (for Melanoma confirmation)
☐ *Acu*Probe™ **Spitz** (for Spitz nevus confirmation)

☐ **NERVE FIBER DENSITY TESTING**

BIOPSY SITE	PAS	DURATION / HISTORY / CLINICAL DIAGNOSIS
A		
B		
C		

CLINICAL DATA (Required): _____

_____

_____

_____

PATIENT INFORMATION

RACE (optional)

SS# ___ ___ - ___ ___ - ___ ___ ___ ___ DATE OF BIRTH ___/___/___ M ☐ F ☐

LAST NAME _____ FIRST NAME _____ M.I. _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

TEL. # _____ CHART # _____ PATH # _____

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. ___/___/___

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 _____

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

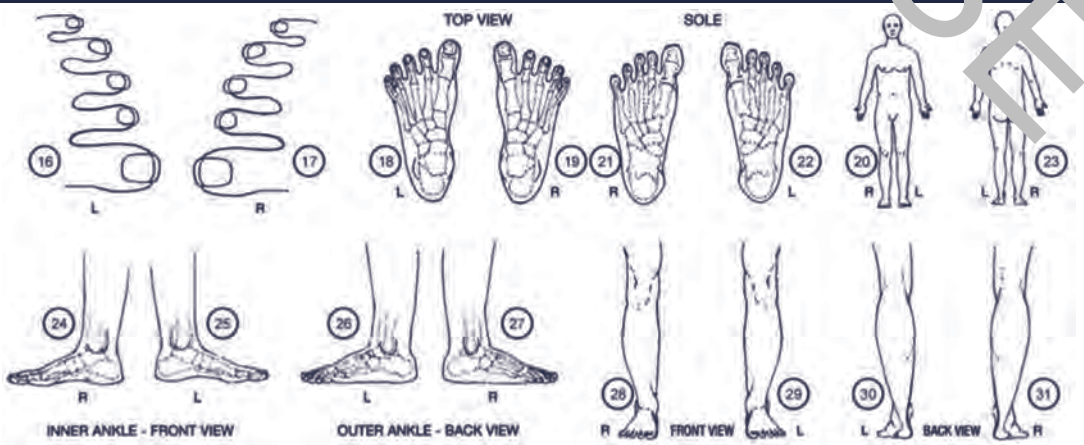
Remove labels and affix to specimen bottles.
(1 label per bottle)

A _____

B _____

C _____

D _____



LABORATORY COPY