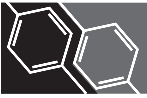

NEW ENGLAND TISSUE ISSUE INC.

SPECIALIZED PATHOLOGY SERVICES WITH A BEDSIDE MANNER

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NAME / last / first		DATE OF COLLECTION	DATE OF ACCESSION (lab use only)
ADDRESS / street or box / city /state / zip			ACCESSION # (lab use only)
D.O.B.	SEX M F	TELEPHONE	PRACTICE MR# (optional)

BILL TO (please circle): BC/MA BC/RI MEDICARE BC/PLAN 65 UNH AETNA CIGNA TUFTS SELF PAY/OTHER

PRIMARY INSURANCE (please attach front/back card copy)	SECONDARY INSURANCE
POLICY HOLDER'S NAME DOB	POLICY HOLDER'S NAME DOB
ID/GROUP NUMBERS	ID/GROUP NUMBERS
BILLING ADDRESS	BILLING ADDRESS

SPECIMEN DATA

1 SITE R L

- CLIPPING
- SHAVE
- PUNCH
- EXCISION

CLINICAL HISTORY

CLINICAL FINDINGS

NAIL
- FUNGUS
- HEMORRAGE

TUMOR / LESION
- WART
- SCC
- MELANOMA
- NEVUS

SOFT TISSUE
- NEUROMA
- FIBROMA

GROSS (lab use only) ______x______x______cm #______

SPECIMEN IS: INKED B/S T/S S/S SUBMITTED: ENTIRELY PARTIALLY

SPECIMEN DATA

2 SITE R L

- CLIPPING
- SHAVE
- PUNCH
- EXCISION

CLINICAL HISTORY

CLINICAL FINDINGS

NAIL
- FUNGUS
- HEMORRAGE

TUMOR / LESION
- WART
- SCC
- MELANOMA
- NEVUS

SOFT TISSUE
- NEUROMA
- FIBROMA

GROSS (lab use only) ______x______x______cm #______

SPECIMEN IS: INKED B/S T/S S/S SUBMITTED: ENTIRELY PARTIALLY

SUBMITTING PHYSICIAN ______________________ SEND COPY OF REPORT TO ______________________

SIGNATURE ______________________ FAX ______________________

PHONE ______________________ FAX ______________________

SPECIMEN REQUIREMENTS: ALL SPECIMENS ARE TO BE SUBMITTED WITH THIS REQUISITION, IN FIXATIVE CONTAINERS LABELED WITH PATIENT NAME, DOB, AND BIOPSY SITE. PHYSICIAN OFFICES WILL BE CONTACTED WHEN SPECIMENS DO NOT MEET THESE REQUIREMENTS PRIOR TO PROCESSING.