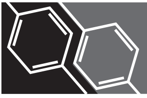

NEW ENGLAND TISSUE ISSUE INC.

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	CLINICAL FINDINGS
1 SITE R L	NAIL ○ FUNGUS ○ HEMORRAGE TUMOR / LESION ○ WART ○ SCC ○ MELANOMA ○ NEVUS SOFT TISSUE ○ NEUROMA ○ FIBROMA
○ CLIPPING ○ SHAVE ○ PUNCH ○ EXCISION	
CLINICAL HISTORY	GROSS (lab use only) ______x______x______cm #______ SPECIMEN IS: ○INKED ○B/S ○T/S ○S/S SUBMITTED: ○ENTIRELY ○PARTIALLY

SPECIMEN DATA	CLINICAL FINDINGS
2 SITE R L	NAIL ○ FUNGUS ○ HEMORRAGE TUMOR / LESION ○ WART ○ SCC ○ MELANOMA ○ NEVUS SOFT TISSUE ○ NEUROMA ○ FIBROMA
○ CLIPPING ○ SHAVE ○ PUNCH ○ EXCISION	
CLINICAL HISTORY	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.