

NEW ENGLAND TISSUE ISSUE

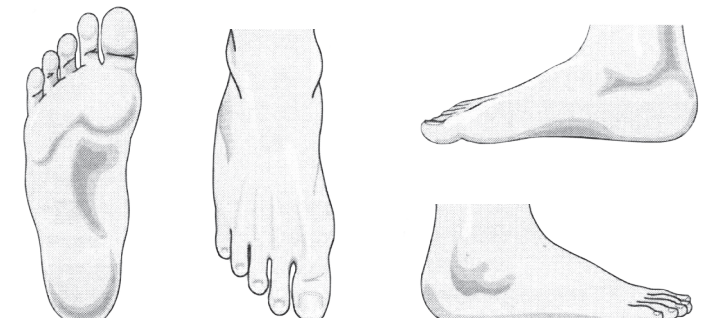
A ProPath Company

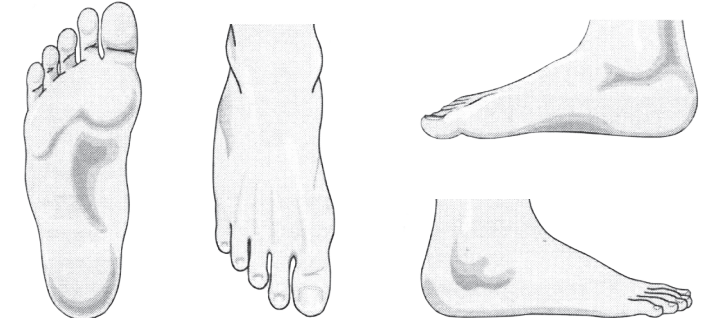
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CLIA LICENSE # 2202015045
TODD VINOVRSKI, M.D., LABORATORY DIRECTOR

| | | | |
|---|------------|--------------------|----------------------------------|
| 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 | | <ul style="list-style-type: none"> <input type="radio"/> FUNGUS <input type="radio"/> HEMORRAGE TUMOR / LESION <input type="radio"/> WART <input type="radio"/> SCC <input type="radio"/> MELANOMA <input type="radio"/> NEVUS SOFT TISSUE <input type="radio"/> NEUROMA <input type="radio"/> FIBROMA |  |
| <input type="radio"/> CLIPPING <input type="radio"/> SHAVE <input type="radio"/> PUNCH <input type="radio"/> EXCISION | | | |
| CLINICAL HISTORY | | | |
| | | GROSS (lab use only) _____x_____x_____cm #_____ | |
| | | SPECIMEN IS: <input type="radio"/> INKED <input type="radio"/> B/S <input type="radio"/> T/S <input type="radio"/> S/S SUBMITTED: <input type="radio"/> ENTIRELY <input type="radio"/> PARTIALLY | |

| | | | |
|--|--|--|--|
| SPECIMEN DATA | | CLINICAL FINDINGS | |
| 2 SITE R L | | <ul style="list-style-type: none"> <input type="radio"/> FUNGUS <input type="radio"/> HEMORRAGE TUMOR / LESION <input type="radio"/> WART <input type="radio"/> SCC <input type="radio"/> MELANOMA <input type="radio"/> NEVUS SOFT TISSUE <input type="radio"/> NEUROMA <input type="radio"/> FIBROMA |  |
| <input type="radio"/> CLIPPING <input type="radio"/> SHAVE <input type="radio"/> PUNCH <input type="radio"/> EXCISION | | | |
| CLINICAL HISTORY | | | |
| | | GROSS (lab use only) _____x_____x_____cm #_____ | |
| | | SPECIMEN IS: <input type="radio"/> INKED <input type="radio"/> B/S <input type="radio"/> T/S <input type="radio"/> S/S SUBMITTED: <input type="radio"/> ENTIRELY <input type="radio"/> PARTIALLY | |

SUBMITTING PHYSICIAN _____ SEND COPY OF REPORT TO _____
 SIGNATURE _____ FAX _____
 PHONE _____ FAX _____

SPECIMEN REQUIREMENTS: ALL SPECIMENS ARE TO BE SUBMITTED WITH THIS REQUIREMENT, 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.