NEW ENGLAND TISSUE ISSUE

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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

1 SITE ○R ○L

- ○ CLIPPING
- ○ SHAVE
- ○ PUNCH
- ○ EXCISION

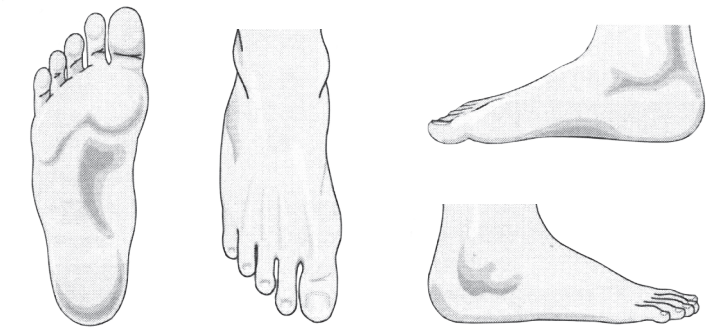
CLINICAL HISTORY

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

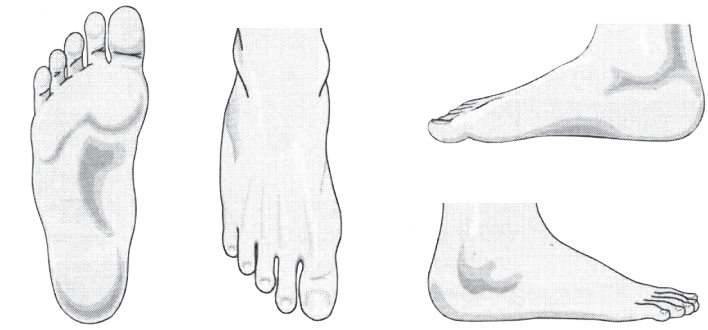
CLINICAL HISTORY

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.