



A ProPath Company

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 TODD VINOVRSKI, M.D., LABORATORY DIRECTOR

| | | | |
|---|--------------|--------------------|-------------------|
| PATIENT NAME / last / first | see attached | DATE OF COLLECTION | DATE OF ACCESSION |
| PATIENT ADDRESS / street or box / city /state / zip | | | PATIENT TELEPHONE |
| PATIENT D.O.B. | | SEX | PRACTICE MR# |

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

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

| SPECIMEN DATA | CLINICAL FINDINGS |
|---|--|
| A <input type="radio"/> PUNCH BIOPSY <input type="radio"/> PUNCH EXCISION (INK) <input type="radio"/> SHAVE BIOPSY <input type="radio"/> SHAVE REMOVAL (INK) <input type="radio"/> EXCISION (INK) <input type="radio"/> CURRETAGE <input type="radio"/> ALOPECIA SECTIONS <input type="radio"/> PAS FUNGAL (NAIL) <input type="radio"/> DIF | <input type="radio"/> NEVUS (ATYPICAL) <input type="radio"/> MELANOMA <input type="radio"/> BCC <input type="radio"/> SCC <input type="radio"/> AK <input type="radio"/> SK <input type="radio"/> FEP |
| | SITE _____ GROSS (lab use only) <input type="radio"/> BROWN <input type="radio"/> TAN <input type="radio"/> GRAY _____x_____x_____mm SPECIMEN IS: <input type="radio"/> INKED <input type="radio"/> SECTIONED SUBMITTED: <input type="radio"/> ENTIRELY <input type="radio"/> PARTIALLY |
| B <input type="radio"/> PUNCH BIOPSY <input type="radio"/> PUNCH EXCISION (INK) <input type="radio"/> SHAVE BIOPSY <input type="radio"/> SHAVE REMOVAL (INK) <input type="radio"/> EXCISION (INK) <input type="radio"/> CURRETAGE <input type="radio"/> ALOPECIA SECTIONS <input type="radio"/> PAS FUNGAL (NAIL) <input type="radio"/> DIF | <input type="radio"/> NEVUS (ATYPICAL) <input type="radio"/> MELANOMA <input type="radio"/> BCC <input type="radio"/> SCC <input type="radio"/> AK <input type="radio"/> SK <input type="radio"/> FEP |
| | SITE _____ GROSS (lab use only) <input type="radio"/> BROWN <input type="radio"/> TAN <input type="radio"/> GRAY _____x_____x_____mm SPECIMEN IS: <input type="radio"/> INKED <input type="radio"/> SECTIONED SUBMITTED: <input type="radio"/> ENTIRELY <input type="radio"/> PARTIALLY |
| C <input type="radio"/> PUNCH BIOPSY <input type="radio"/> PUNCH EXCISION (INK) <input type="radio"/> SHAVE BIOPSY <input type="radio"/> SHAVE REMOVAL (INK) <input type="radio"/> EXCISION (INK) <input type="radio"/> CURRETAGE <input type="radio"/> ALOPECIA SECTIONS <input type="radio"/> PAS FUNGAL (NAIL) <input type="radio"/> DIF | <input type="radio"/> NEVUS (ATYPICAL) <input type="radio"/> MELANOMA <input type="radio"/> BCC <input type="radio"/> SCC <input type="radio"/> AK <input type="radio"/> SK <input type="radio"/> FEP |
| | SITE _____ GROSS (lab use only) <input type="radio"/> BROWN <input type="radio"/> TAN <input type="radio"/> GRAY _____x_____x_____mm SPECIMEN IS: <input type="radio"/> INKED <input type="radio"/> SECTIONED 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 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.