INTEGRATED
PATHOLOGY

SCIENTIFIC DIAGNOSES AND LABORATORY SOLUTIONS

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RESET FORM

PODIATRY DERMATOPATHOLOGY REQUISITION

CLIENT INFORMATION:

PATIENT INFORMATION

Patient Name: _____
(LAST, FIRST)
DOB: _____ Age: _____ Gender: ☐ Male ☐ Female
Street Address: _____
City: _____ State:_____ Zip Code: _____
Patient ID #: _____ SSN#: _____
Submitting Physician: _____
Patient Phone #:_____ Referring Physician: _____
Date of Collection:_____ Time of Collection: _____

BILLING INFORMATION

Please provide the current ICD-10 code(s): _____
Please complete billing information below or attach a separate sheet and a copy of insurance card with the necessary information:
Insurance Company State Name of Employer
_____
Policy No. Group No.
_____
Insurance Company Street Address City State Zip Code
_____
Name of Insured (if other than patient):_____
Patient's relationship to insured: ☐ Spouse ☐ Child ☐ Other, Explain
IP Pathologists may order additional testing based on medical necessity.

CLINICAL DATA

Previous Surgery: ☐ Yes ☐ No Previous Therapy: ☐ Chemotherapy ☐ Radiation
Previous Biopsy: ☐ Yes ☐ No ☐ Hormonal therapy ☐ Diabetes
Previous diagnosis: ☐ Yes ☐ No ☐ Other:_____

CLINICAL DIAGNOSIS

BIOPSY SITE	CHECK BOX
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER
	☐ SHAVE ☐ PUNCH ☐ EXCISION ☐ OTHER
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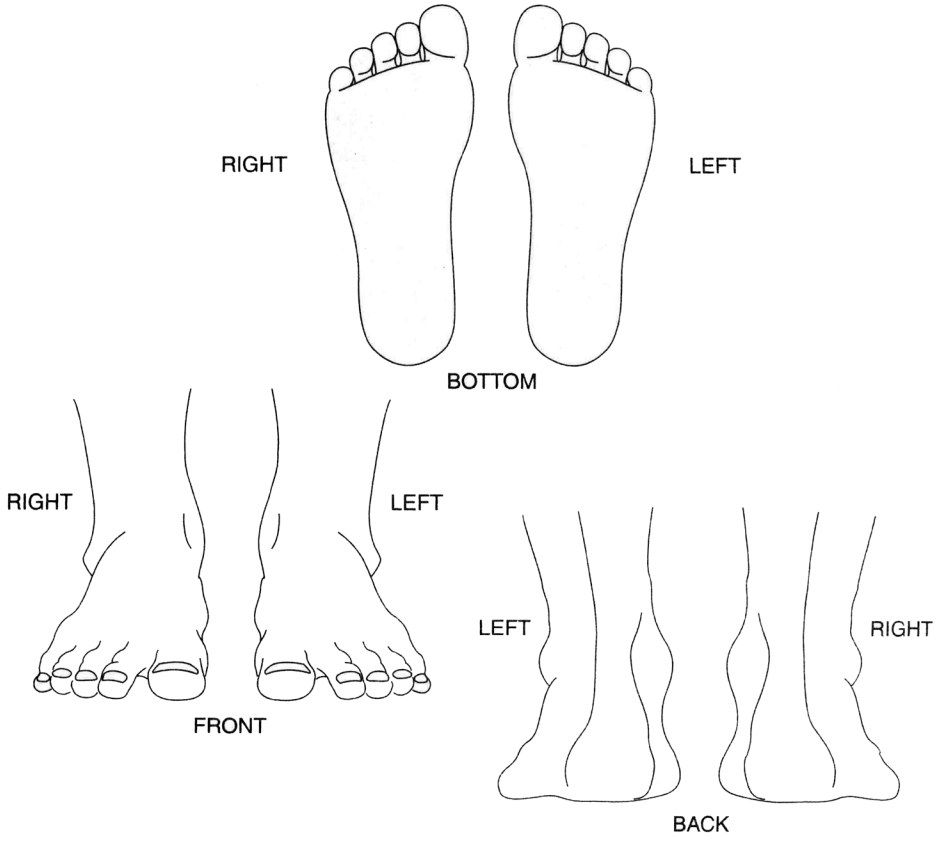

RESET FORM

IPS USE ONLY: Received Date & Time: Assigned Case #: