Cleveland Clinic Laboratories

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

☐ STAT

DERMATOPATHOLOGY REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date | Sex ☐ M ☐ F

City | SS #

State | Zip | Home Phone

Hospital/Physician Office Patient ID # | Accession #

CLIENT INFORMATION

MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

INSURANCE BILLING INFORMATION (PLEASE ATTACH CARD OR PRINT IN BLACK INK)

BILL TO: ☐ Client/Institution ☐ Medicare ☐ Insurance (Complete insurance information below) ☐ Patient

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital discharge date: _____/_____/_____

PRIMARY: ☐ Medicare ☐ Medicaid ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

SECONDARY: ☐ No ☐ Yes (if Yes, please attach)

ORDERING PHYSICIAN CONTACT

Physician Name

Physician NPI#

Physician Phone

Physician Email

Date Collected: _____/_____/_____ Collected By: _____

☐ Call Results to phone number: (_____) _____

☐ Fax report to: (_____) _____

DIAGNOSIS CODE (REQUIRED) ICD-9 Codes: 1. _____ 2. _____ 3. _____

☐ Consultation on Prepared Slides/Blocks

SPECIMEN A

Check off Appropriate Type of Biopsy:

- ☐ Punch
- ☐ Punch Excision
- ☐ Shave
- ☐ Shave Excision
- ☐ Curettings
- ☐ Excision
- ☐ Wide Excision

Margins: ☐ Yes ☐ No

Biopsy Site: _____

Clinical History: _____

Additional Tests:

- ☐ Direct Immunofluorescense
- ☐ Immunohistochemistry
  - Stain: _____
- ☐ Melanoma FISH
- ☐ BRAF V600
- ☐ T-Cell Clonality (*TCRB* and *TCRG*)
- ☐ B-Cell Clonality (*IGH* and *IGK*)
- ☐ Electron Microscopy
- ☐ Other: _____

SPECIMEN B

Check off Appropriate Type of Biopsy:

- ☐ Punch
- ☐ Punch Excision
- ☐ Shave
- ☐ Shave Excision
- ☐ Curettings
- ☐ Excision
- ☐ Wide Excision

Margins: ☐ Yes ☐ No

Biopsy Site: _____

Clinical History: _____

Additional Tests:

- ☐ Direct Immunofluorescense
- ☐ Immunohistochemistry
  - Stain: _____
- ☐ Melanoma FISH
- ☐ BRAF V600
- ☐ T-Cell Clonality (*TCRB* and *TCRG*)
- ☐ B-Cell Clonality (*IGH* and *IGK*)
- ☐ Electron Microscopy
- ☐ Other: _____

SPECIMEN C

Check off Appropriate Type of Biopsy:

- ☐ Punch
- ☐ Punch Excision
- ☐ Shave
- ☐ Shave Excision
- ☐ Curettings
- ☐ Excision
- ☐ Wide Excision

Margins: ☐ Yes ☐ No

Biopsy Site: _____

Clinical History: _____

Additional Tests:

- ☐ Direct Immunofluorescense
- ☐ Immunohistochemistry
  - Stain: _____
- ☐ Melanoma FISH
- ☐ BRAF V600
- ☐ T-Cell Clonality (*TCRB* and *TCRG*)
- ☐ B-Cell Clonality (*IGH* and *IGK*)
- ☐ Electron Microscopy
- ☐ Other: _____

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