**LINCOLN DIAGNOSTICS LLC.**
**37 Josephine Street, Staten Island, NY 10314**
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Diagnosis@LincolnLab.us

Specimen #

**For Lab Use ONLY**

# DERMATOPATHOLOGY REQUISITION

## CLIENT INFORMATION

Requesting Physician _____

## PATIENT INFORMATION

Last Name | First Name | M.I.

Date of Birth *(Required)* _____/_____/_____ | Gender *(Req.)* ☐ ☐ | Date Specimen Collected *(Req.)* _____/_____/_____

Street Address | Apt. #

City | State | Zip

Social Security # | Telephone #

## BILLING INFORMATION

*PLEASE ATTACH A COPY OF THE INSURANCE CARD (FRONT AND BACK), OR FILL IN THE NECESSARY INFORMATION BELOW, THANK YOU*

☐ **Check here if self-pay** (If checked, please, attach the acknowledgment form)

☐ **Secondary insurance exists.** If checked, please include a photocopy of both carriers and clearly indicate primary and secondary.

Insurance Carrier: | Address | City | State | Zip

Name of Insured *(if different from patient)*: | Insurance ID: | Group #

DOB of Insured _____/_____/_____ | Gender M☐ F☐

Relationship to subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

## PROCEDURE (Check all that apply)

| | BIOPSY: Shave | Punch | Curette | Excision | Other | Left | Right | CLINICAL IMPRESSION | RELEVANT HISTORY/ PREVIOUS BIOPSY |
|---|---|---|---|---|---|---|---|---|---|
| **A** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| | Anatomic Specimen Site A | | | | | | | | |
| **B** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| | Anatomic Specimen Site B | | | | | | | | |
| **C** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| | Anatomic Specimen Site C | | | | | | | | |
| **D** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | |
| | Anatomic Specimen Site D | | | | | | | | |

*X*

Physician's Signature *(required in NY, NJ, MA and PA)* Date

NOTE: SPECIMEN CONTAINERS MUST INCLUDE PATIENT NAME AND BIOPSY SITE