AURORA DIAGNOSTICS

Pathology Solutions

DERMATOPATHOLOGY REQUISITION

COLLECTION DATE:

☐ **STAT or RUSH**

GI00001

Accession - Lab Use Only

PATIENT INFORMATION

LAST NAME | FIRST NAME | MI

DATE OF BIRTH (MM / DD / YYYY) | MRN # / PAT. CHART #

SOCIAL SECURITY NUMBER | SEX ☐ M ☐ F

STREET ADDRESS

CITY/STATE/ZIP

HOME PHONE NUMBER | WORK PHONE NUMBER

CLIENT INFORMATION

Referring Physician:_____

COPIES TO:

INSURANCE INFORMATION

☐ BILL TO INSURANCE: COPY ID CARD(S) FRONT & BACK OR COMPLETE BELOW

☐ BILL PATIENT ☐ BILL PHYSICIAN

PRIMARY INSURANCE

CITY/STATE/ZIP

POLICY # | GROUP #

MEDICARE NUMBER

GROUP EMPLOYER

NAME OF POLICY HOLDER

SECONDARY INSURANCE

CITY/STATE/ZIP

POLICY # | GROUP #

GROUP EMPLOYER

NAME OF POLICY HOLDER

CLINICAL INFORMATION

SITE	PROCEDURE TYPE		MARGINS		RULE OUT		CLINICAL DIAGNOSIS
A	☐ Biopsy ☐ Re-Excision ☐ Punch	☐ Excision ☐ Shave ☐ Curette	Immuno ☐ Direct ☐ Indirect	Margins? ☐ Yes ☐ No	☐ AK ☐ DN ☐ SCC ☐ MM	☐ SK ☐ N ☐ BCC	
B	☐ Biopsy ☐ Re-Excision ☐ Punch	☐ Excision ☐ Shave ☐ Curette	Immuno ☐ Direct ☐ Indirect	Margins? ☐ Yes ☐ No	☐ AK ☐ DN ☐ SCC ☐ MM	☐ SK ☐ N ☐ BCC	
C	☐ Biopsy ☐ Re-Excision ☐ Punch	☐ Excision ☐ Shave ☐ Curette	Immuno ☐ Direct ☐ Indirect	Margins? ☐ Yes ☐ No	☐ AK ☐ DN ☐ SCC ☐ MM	☐ SK ☐ N ☐ BCC	
D	☐ Biopsy ☐ Re-Excision ☐ Punch	☐ Excision ☐ Shave ☐ Curette	Immuno ☐ Direct ☐ Indirect	Margins? ☐ Yes ☐ No	☐ AK ☐ DN ☐ SCC ☐ MM	☐ SK ☐ N ☐ BCC	
E	☐ Biopsy ☐ Re-Excision ☐ Punch	☐ Excision ☐ Shave ☐ Curette	Immuno ☐ Direct ☐ Indirect	Margins? ☐ Yes ☐ No	☐ AK ☐ DN ☐ SCC ☐ MM	☐ SK ☐ N ☐ BCC	
F	☐ Biopsy ☐ Re-Excision ☐ Punch	☐ Excision ☐ Shave ☐ Curette	Immuno ☐ Direct ☐ Indirect	Margins? ☐ Yes ☐ No	☐ AK ☐ DN ☐ SCC ☐ MM	☐ SK ☐ N ☐ BCC	
G	☐ Biopsy ☐ Re-Excision ☐ Punch	☐ Excision ☐ Shave ☐ Curette	Immuno ☐ Direct ☐ Indirect	Margins? ☐ Yes ☐ No	☐ AK ☐ DN ☐ SCC ☐ MM	☐ SK ☐ N ☐ BCC	
H	☐ Biopsy ☐ Re-Excision ☐ Punch	☐ Excision ☐ Shave ☐ Curette	Immuno ☐ Direct ☐ Indirect	Margins? ☐ Yes ☐ No	☐ AK ☐ DN ☐ SCC ☐ MM	☐ SK ☐ N ☐ BCC	

AURORA DIAGNOSTICS PROOF

Physician's Signature (required):_____ **Date:**_____

246 INDUSTRIAL WAY WEST, SUITE 2 • EATONTOWN, NJ 07724 • P 732.389.5200 / F 732.389.5299

AURORA DIAGNOSTICS Pathology Solutions GI00001-A

A Patient Name:_____ Site A:_____

AURORA DIAGNOSTICS Pathology Solutions GI00001-B

B Patient Name:_____ Site B:_____

AURORA DIAGNOSTICS Pathology Solutions GI00001-C

C Patient Name:_____ Site C:_____

AURORA DIAGNOSTICS Pathology Solutions GI00001-D

D Patient Name:_____ Site D:_____

AURORA DIAGNOSTICS Pathology Solutions GI00001-E

E Patient Name:_____ Site E:_____

AURORA DIAGNOSTICS Pathology Solutions GI00001-F

F Patient Name:_____ Site F:_____

AURORA DIAGNOSTICS Pathology Solutions GI00001-G

G Patient Name:_____ Site G:_____

AURORA DIAGNOSTICS Pathology Solutions GI00001-H

H Patient Name:_____ Site H:_____