Regional DermPath Consultants, S.C.

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DERMATOPATHOLOGY REQUISITION FORM

Physician Information

Doctor's Name/Office:

Date of Service:

Fax/Call Results to #: STAT: ☐

Patient Information

Patient's Name:		Address Number & Street:		
Social Security #:		City:	State:	Zip Code:
Date of Birth:	Sex: M ☐ F ☐	Ethnic Origin:		

Biopsy Information

Biopsy Site	Method	Clinical Description/Impression/Comments
A.	Punch ☐ Shave ☐ Excision ☐ Other:	
B.	Punch ☐ Shave ☐ Excision ☐ Other:	
C.	Punch ☐ Shave ☐ Excision ☐ Other:	
D.	Punch ☐ Shave ☐ Excision ☐ Other:	
E.	Punch ☐ Shave ☐ Excision ☐ Other:	

Insurance Information

****Please attach a copy of the patient's insurance card****

Insurance Company and Plan Name: _____
Insurer's ID# _____ Group Number _____
Policy Holder's Name _____ Relationship to Insured: Self ____ Spouse ____ Child ____ Other ____

Lab Use Only: