SUBMITTING CLINICIAN INFORMATION

Office Name

Submitting Physician Name

Address

City State ZIP Code

Telephone Number Fax Number

ONE CRANBERRY HILL, SUITE 303
LEXINGTON, MA 02421
Telephone: 877-872-8223 Fax: 781-290-0059

PATIENT INFORMATION

Date of Birth

Sex: ☐ Female ☐ Male

Name (Last, First, Middle Initial)

Address

City State ZIP Code

Telephone Number

Medical Record Number (Optional)

BILLING INFORMATION

Primary Insurance	Secondary Insurance
Insurance Company	Insurance Company
Member ID	Member ID
Group Number	Group Number
Insured Name	Insured Name
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent	Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

SEND ADDITIONAL COPY OF REPORT TO

Doctor's Name Address

City State ZIP Code

SPECIMEN INFORMATION

DATE OF PROCEDURE: _____ **Physician Signature:** _____

Physician authorizes Strata Pathology Services to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient accordingly

Write patient name/initials on all specimen bottles

NAIL

Location				Procedure Type				Clinical Impression
Hand ☐	Foot ☐	Left ☐	Right ☐	Fungal Nail* ☐	Nail Removal Gross Only ☐	Biopsy ☐	Excision ☐	
Hand ☐	Foot ☐	Left ☐	Right ☐	Fungal Nail* ☐	Nail Removal Gross Only ☐	Biopsy ☐	Excision ☐	

SKIN

Location	Procedure Type						Clinical Impression
	Shave ☐	Punch ☐	Biopsy ☐	Excision ☐	Re-Excision ☐	Curetting ☐	
	Shave ☐	Punch ☐	Biopsy ☐	Excision ☐	Re-Excision ☐	Curetting ☐	

OTHER

Location	Procedure Type	Clinical Impression

*Standard protocol stain: PAS/GMS