

DATE OF PROCEDURE: _____

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

Please attach copy of patient's insurance card

Insurance Information Attached Insurance not on file, Contact Patient directly to obtain

Client Bill Please Bill the Patient Directly

INSURANCE 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Patient's Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent

SPECIMEN INFORMATION

	PROCEDURE TYPE	BIOPSY SITE	CLINICAL IMPRESSION	
A	NAIL UNIT DYSTROPY (Fungal, Inflammatory, Neoplasm) <input type="checkbox"/> Nail - High Sensitivity (PAS/GMS) <input type="checkbox"/> Nail - Low Sensitivity (PAS) <input type="checkbox"/> Reflex to PCR/DNA, only if positive (3-4 days) <input type="checkbox"/> Always add PCR/DNA (2 days) <input type="checkbox"/> Reflex to Culture, only if negative (2-4 weeks)	Skin/Tissue <input type="checkbox"/> Excision <input type="checkbox"/> Re-Excision <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Curette		
B	NAIL UNIT DYSTROPY (Fungal, Inflammatory, Neoplasm) <input type="checkbox"/> Nail - High Sensitivity (PAS/GMS) <input type="checkbox"/> Nail - Low Sensitivity (PAS) <input type="checkbox"/> Reflex to PCR/DNA, only if positive (3-4 days) <input type="checkbox"/> Always add PCR/DNA (2 days) <input type="checkbox"/> Reflex to Culture, only if negative (2-4 weeks)	Skin/Tissue <input type="checkbox"/> Excision <input type="checkbox"/> Re-Excision <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Curette		
C	NAIL UNIT DYSTROPY (Fungal, Inflammatory, Neoplasm) <input type="checkbox"/> Nail - High Sensitivity (PAS/GMS) <input type="checkbox"/> Nail - Low Sensitivity (PAS) <input type="checkbox"/> Reflex to PCR/DNA, only if positive (3-4 days) <input type="checkbox"/> Always add PCR/DNA (2 days) <input type="checkbox"/> Reflex to Culture, only if negative (2-4 weeks)	Skin/Tissue <input type="checkbox"/> Excision <input type="checkbox"/> Re-Excision <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Curette		

A	B	C
Patient Name/Initials: _____	Patient Name/Initials: _____	Patient Name/Initials: _____
DOB: _____	DOB: _____	DOB: _____
Site: _____	Site: _____	Site: _____
<i>To ensure processing, affix completed label to specimen container.</i>	<i>To ensure processing, affix completed label to specimen container.</i>	<i>To ensure processing, affix completed label to specimen container.</i>

FORWARD ADDITIONAL COPY OF REPORT TO

*Dr. Name (first, last): _____

*Fax: _____

***Required information to forward reports**

Physician Signature: REQUIRED

_____ Date: _____

The requested test(s) is/are medically indicated for patient management.

I certify that I have obtained the required authorization and assignment of benefits for the laboratory to bill when insurance billing has been requested above. Physician authorizes Strata Pathology Services to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient accordingly.

Specimen container must include patient Name, Site and Corresponding Label.