StrataDx
ONE CRANBERRY HILL
SUITE 303
LEXINGTON, MA 02421
Phone: 800-325-7284 Fax: 617-401-4032

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: ☐ Self ☐ Spouse ☐ Dependent	Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

SPECIMEN INFORMATION

	SKIN	BIOPSY SITE	CLINICAL IMPRESSION
A	☐ Biopsy ☐ Excision ☐ Shave ☐ Punch ☐ Curette ☐ DIF		
B	☐ Biopsy ☐ Excision ☐ Shave ☐ Punch ☐ Cure ☐ DIF		
C	☐ Biopsy ☐ Excision ☐ Shave ☐ Punch ☐ Cure ☐ DIF		
D	☐ Biopsy ☐ Excision ☐ Shave ☐ Punch ☐ Cure ☐ DIF		

NAIL	BIOPSY SITE	CLINICAL IMPRESSION
Nail Unit Dystrophy (Fungal, Inflammatory, Neoplasm) ☐ Nail - High Sensitivity (PAS/GMS) ☐ Nail - Low Sensitivity (PAS) ☐ Reflex to PCR/DNA, only if positive (3-4 days) ☐ Always add PCR/DNA (2 days) ☐ Reflex to Culture, only if negative (2-4 weeks)		

Patient Name/Initials: _____	**Patient Name/Initials:** _____	**Patient Name/Initials:** _____
DOB: **Site:** ** Affix completed label to specimen container.*	**DOB:** **Site:** ** Affix completed label to specimen container.*	**DOB:** **Site:** ** Affix completed label to specimen container.*
Patient Name/Initials: _____	**Patient Name/Initials:** _____	**Patient Name/Initials:** _____
DOB: **Site:** ** Affix completed label to specimen container.*	**DOB:** **Site:** ** Affix completed label to specimen container.*	**DOB:** **Site:** ** Affix completed label to specimen container.*

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.