Histology Associates
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CLIA#: 23D0650582
CAP#: 3418201

Pathology Requisition

1.800.444.PLAB

Patient Case #

PATIENT INFORMATION

Patient Name (Last, First, MI)	Phone #	DOB	Gender M or F
Address	City	State	Zip

PROVIDER INFORMATION

Provider Name (Last, First, MI)	Provider NPI #	Referring Provider Code
Provider Signature	Provider Email Address	Provider Phone #

INSURANCE INFORMATION

Bill to: ☐ Patient ☐ Medicare ☐ Insurance

Insurance 1	ID #	Group #	Claims Mailing Address
Insurance 2	ID #	Group #	Claims Mailing Address

Date of Service	Date Received by Lab	Additional Notes

PATIENT CONSENT

I hereby authorize you to submit my specimen to Histology Associates, Inc. I understand that there will be a separate pathology service billed to my insurance company and/or myself.

Patient Name (please print)	Patient Signature	Date

Specimen Details

Specimen #1 : ☐ Right ☐ Left ☐ Biopsy ☐ Excision ☐ Punch ☐ Shave

Collection Date	Date Received by Lab	Pre-Operative Diagnosis

Specimen #2 : ☐ Right ☐ Left ☐ Biopsy ☐ Excision ☐ Punch ☐ Shave

Collection Date	Date Received by Lab	Pre-Operative Diagnosis

Specimen #3 : ☐ Right ☐ Left ☐ Biopsy ☐ Excision ☐ Punch ☐ Shave

Collection Date	Date Received by Lab	Pre-Operative Diagnosis

Test for Selected Options Below

- ☐ Bone Degeneration
- ☐ Cyst
- ☐ Nail Fungus: (KOH/PAS)
- ☐ Nail Culture
- ☐ Nail Malignancy
- ☐ Skin Fungus
- ☐ Skin Malignancy
- ☐ Tumor
- ☐ Ulcer
- ☐ Verruca
- ☐ Wound Culture w/ Sensitivity & ID*
- ☐ Other: ______________________________

Skeletal

R R

L R L L

Nail, Skin, Soft Tissue

R R L R

L L L R

REMARKS

*sendout