SBMF
South Bend Medical Foundation
3355 Douglas Road, South Bend, IN 46635

DERMATOPATHOLOGY REQUISITION

Client Name: ____________________

✓ Physician's Last Name, First Name
[ ] ____________________
[ ] ____________________
[ ] ____________________
[ ] ____________________
[ ] ____________________
[ ] ____________________

SIGNATURE OF ORDERING PROVIDER
(Signature must be dated, legible, and include first and last name)

____

DATE ____________________

CONSULTING PHYSICIAN (First and Last Name)

____

BILLING

☐ PHYSICIAN / ACCOUNT
☐ PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION ATTACHED
☐ BCCP, ALPHA ID #__________

IF NO BILLINGINFORMATION IS PROVIDED AND NO BOX IS CHECKED, YOUR ACCOUNT WILL BE BILLED.

PATHOLOGY USE ONLY
ACCESSION #
(place label here)

PATIENT INFORMATION

Name ____________________ (Last / First / MI) DOB__________ (MO / DAY / YEAR) AGE ______ SEX ______

Patient Address ____________________ City, State, ZIP code ____________________

SSN ____________ MRN ____________ ☐ Inpatient ☐ Outpatient

CLINICAL INFORMATION

SPECIMEN 1

Date of Collection __________
Time of Collection __________
☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Clinical Findings:

Differential Diagnosis:

SPECIMEN 2

Date of Collection __________
Time of Collection __________
☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Clinical Findings:

Differential Diagnosis:

SPECIMEN 3

Date of Collection __________
Time of Collection __________
☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Clinical Findings:

Differential Diagnosis:

SPECIMEN 4

Date of Collection __________
Time of Collection __________
☐ Punch ☐ Shave
☐ Excision ☐ Re-Excision
☐ Alopecia Sections
☐ Direct Immunofluorescence
Margins: ☐ Yes ☐ No

Anatomic Site:

Clinical Findings:

Differential Diagnosis: