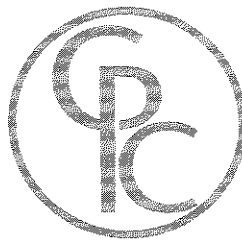


Consolidated Pathology Consultants

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Libertyville, Illinois 60048
Phone (877) 631-PATH (7284)
Fax (847) 996-1076



DERMATOPATHOLOGY REQUISITION

Patient Data				Billing Information (Continued)					
Name (Last, First)				Responsible Party (Last, First) Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other					
Patient I.D. or SSN		Office MR #		Address		Apt. No.			
Date of Birth (Month, Day, Year)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date Collected	Time Collected	City State		Zip			
Physician Signature (Required for Medicaid)		Physician Medicaid #	NPI #	Patient Phone No. ()					
Additional Reports to:				Medicare I.D. Number		Medicare I.D. Number (incl. Suffix)			
				Primary Insurance Name and Plan				HMO	Y <input type="checkbox"/> N <input type="checkbox"/>
				Policy I.D. Number		Group No.			
Billing Information									
<input type="checkbox"/> Account <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance <input type="checkbox"/> Patient				Street City State Zip					
<i>MEDICARE PATIENTS: Please complete the Advanced Beneficiary Notice (ABN) and attach to the requisition when submitting a specimen.</i>									
ICD Diagnosis Codes (Enter All That Apply)									
①		②		③		④			
⑤									
CLINICAL INFORMATION									
SITE:		PROCEDURES:		MARGINS:		CLINICAL DIAGNOSIS AND HISTORY:			
<input type="checkbox"/> IMMUNOFLUORESCENCE <input type="checkbox"/> CULTURE		<input type="checkbox"/> CURRETTINGS <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER		<input type="checkbox"/>					
<input type="checkbox"/> IMMUNOFLUORESCENCE <input type="checkbox"/> CULTURE		<input type="checkbox"/> CURRETTINGS <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER		<input type="checkbox"/>					
<input type="checkbox"/> IMMUNOFLUORESCENCE <input type="checkbox"/> CULTURE		<input type="checkbox"/> CURRETTINGS <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER		<input type="checkbox"/>					
<input type="checkbox"/> IMMUNOFLUORESCENCE <input type="checkbox"/> CULTURE		<input type="checkbox"/> CURRETTINGS <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER		<input type="checkbox"/>					
<input type="checkbox"/> IMMUNOFLUORESCENCE <input type="checkbox"/> CULTURE		<input type="checkbox"/> CURRETTINGS <input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION <input type="checkbox"/> OTHER		<input type="checkbox"/>					
PHYSICIAN'S SIGNATURE X _____				DATE _____					

FOR LAB USE ONLY			
<input type="checkbox"/> 88304	<input type="checkbox"/> 88312	<input type="checkbox"/> 88321	<input type="checkbox"/> 88331
<input type="checkbox"/> 88305	<input type="checkbox"/> 88313	<input type="checkbox"/> 88323	
<input type="checkbox"/> 88311	<input type="checkbox"/> 88342	<input type="checkbox"/> 88346	

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 WENHUA LIU, M.D., PH.D.
 THOMAS F. MIENTUS, M.D.