Client Information

Weill Cornell Medicine
Dermatopathology

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☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Physician's Office/Other

Code 128

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PATIENT INFORMATION

PATIENT LAST NAME | PATIENT FIRST NAME | HISTORY NUMBER

PATIENTS AGE | DATE OF BIRTH | MO. | DAY | YR. | SEX ☐ Male ☐ Female

INSURANCE IDENTIFICATION NUMBER | GROUP NUMBER

BILLING INFORMATION

BILL ▶ ☐ MEDICARE ☐ MEDICAID ☐ RESPONSIBLE PARTY ☐ INSURANCE ☐ PATIENT ☐ CLIENT

NAME OF INSURANCE CARRIER/GUARANTOR

ADDRESS OF INSURANCE CARRIER/GUARANTOR

BILL TO NAME OR SECONDARY INSURANCE INFORMATION (IF DIFFERENT FROM ABOVE)
LAST | FIRST

PATIENT'S ADDRESS | APT. NO.

CITY

STATE | ZIP CODE | PATIENTS TELEPHONE NUMBER AREA CODE

PLEASE AFFIX ONE LABEL TO EACH JAR.

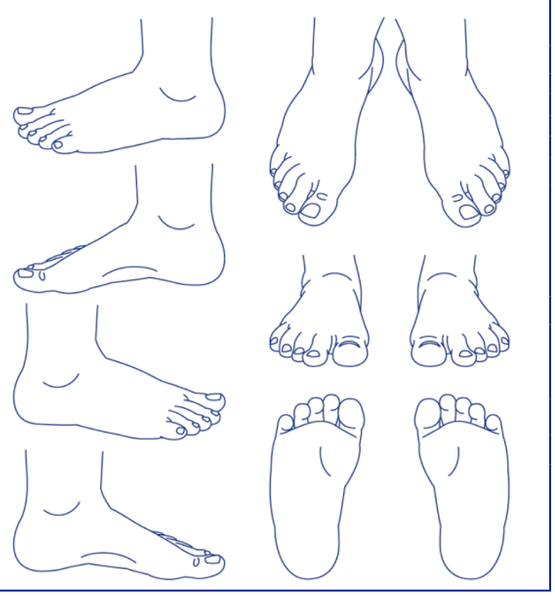
Distance from top of form to bottom of label = 4.75"
Distance from left side of form to left side of label = 4.75"
(On continuous forms this includes the stub.)
Label width = 4"
Label depth = 1.3125"

SIGNIFICANT CLINICAL HISTORY (REQUIRED FOR PROCESSING)

ICD-10 CODES:

BIOPSY PROCEDURE | PLEASE CIRCLE: PUNCH SLICE INCISION EXCISION CURETTE OTHER | SPECIMEN DATE MO. DAY YR. | NO. OF SPECIMENS

SPECIMEN 1 ___Left ___Right ___Formalin ___ Michel's Fixative	**SPECIMEN 2** ___Left ___Right ___Formalin ___ Michel's Fixative
Skin/Soft Tissue	**Skin/Soft Tissue**
___Pigmented Lesion (Nevus/Melanoma/Lentigo)	___Pigmented Lesion (Nevus/Melanoma/Lentigo)
___Tumor (Verruca/Keratosis/Carcinoma)	___Tumor (Verruca/Keratosis/Carcinoma)
___Ulcer (Rule out neoplasm)	___Ulcer (Rule out neoplasm)
___Other :	___Other :
Nail Unit	**Nail Unit**
___Nail Dystrophy (Onychomycosis/Psoriasis/Trauma)	___Nail Dystrophy (Onychomycosis/Psoriasis/Trauma)
___PAS provides higher sensitivity than KOH	___PAS provides higher sensitivity than KOH
___Pigmented Lesion (Nevus/Melanoma/Lentigo)	___Pigmented Lesion (Nevus/Melanoma/Lentigo)
___Tumor (Verruca/Keratosis/Carcinoma)	___Tumor (Verruca/Keratosis/Carcinoma)
___Ulcer (Rule out neoplasm)	___Ulcer (Rule out neoplasm)
___Other :	___Other :
Bone	**Bone**
___Osteomyelitis (Infectious)	___Osteomyelitis (Infectious)
___Tumor (Cyst/Neoplasm)	___Tumor (Cyst/Neoplasm)
___Degenerative Joint Disease (Hallux abducto-valgus/Hammer toe)	___Degenerative Joint Disease (Hallux abducto-valgus/Hammer toe)
___Other :	___Other :
Small Fiber Neuropathy, Reflex Sympathetic Dystrophy, and Erythromyaliga Testing	**Small Fiber Neuropathy, Reflex Sympathetic Dystrophy, and Erythromyaliga Testing**
___ Clinical History Required (see above)	___ Clinical History Required (see above)
Microbiology	**Microbiology**
___(C ANA) Anaerobe Source _____	___(C ANA) Anaerobe Source _____
___(C FUN DERM) Fungal, Dermal Source _____	___(C FUN DERM) Fungal, Dermal Source _____
___(C AFB/SM) AFB Culture w/smear Source _____	___(C AFB/SM) AFB Culture w/smear Source _____
___(C HSV) Viral, Herpes Simplex Only Source _____	___(C HSV) Viral, Herpes Simplex Only Source _____
___(C VIRAL) Virus _____ Source _____	___(C VIRAL) Virus _____ Source _____



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1. PLEASE HAVE PATIENT SIGN THE ADVANCE BENEFICIARY NOTICE (ABN) ON THE BACK OF THE FIRST PAGE.
2. ALL DERMATOPATHOLOGY SPECIMENS MUST BE LABELED WITH PATIENT NAME, SOURCE OF SPECIMEN, SPECIMEN COLLECTION DATE.
3. ADDITIONAL ANCILLARY STUDIES, SUCH AS SPECIAL STAINING TECHNIQUES AND MARKER STUDIES, ARE PERFORMED AT THE DISCRETION OF THE PATHOLOGIST TO PROPER DIAGNOSIS, UNLESS OTHERWISE INDICATED ON THE REQUISITION.

DERMAPATH COPY