



<b>PATIENT INFORMATION</b>	Last	First	M
	SSN		
	Date of birth	Sex (circle one) M      F	
	Address		
	City, State ZIP		
	Phone		

<b>PHYSICIAN INFORMATION</b>	Collection Date
	Office site
	Ordering physician
	Primary care / Copies to
	PRECERT / PREAUTHORIZATION / REFERRAL #

**Label specimens with patient info and tissue type submitted and place in bio-bag**

**Please attach photocopy of patient's insurance card**

**ADDITIONAL CLINICAL HISTORY / MEDICATIONS / ICD-9**


- Routine Diagnosis   
  DIF   
  Slide Prep   
  Consultation on Submitted Slides

**Specimens**

Biopsy Information (Please specify site below)

Specimen	Site	Specimen Type <i>(Shave, Punch, Excision, Biopsy, etc.)</i>	Clinical History
A/1	_____	_____	_____
B/2	_____	_____	_____
C/3	_____	_____	_____
D/4	_____	_____	_____
E/5	_____	_____	_____

Total Number of Containers \_\_\_\_\_