COCKERELL DERMATOPATHOLOGY™
Diagnostic Excellence. Unparalleled Service.™

CLAY J. COCKERELL, M.D.
Medical Director

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TECHNICAL REQUISITION

PATIENT LAST FIRST MI ( ) DAYTIME PHONE

ADDRESS STREET/APT.# CITY ST ZIP CODE EMAIL (FOR PATIENT EDUCATION USE ONLY)

DOB / / SEX RACE OFFICE: PATIENT ID#

DATE COLLECTED / /

○ PREVIOUS BIOPSY AND DIAGNOSIS

CLINICAL INFORMATION

	REQUEST	SPECIMEN SITE	BX TYPE	CLINICAL IMPRESSION / HISTORY / ICD-9 CODE	FOR LAB USE ONLY
A	○ RUSH ○ MARGINS ○ DIF ○ PAS ○ CULTURE		○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		
B	○ RUSH ○ MARGINS ○ DIF ○ PAS ○ CULTURE		○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		
C	○ RUSH ○ MARGINS ○ DIF ○ PAS ○ CULTURE		○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		
D	○ RUSH ○ MARGINS ○ DIF ○ PAS ○ CULTURE		○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		
E	○ RUSH ○ MARGINS ○ DIF ○ PAS ○ CULTURE		○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		
F	○ RUSH ○ MARGINS ○ DIF ○ PAS ○ CULTURE		○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		
G	○ RUSH ○ MARGINS ○ DIF ○ PAS ○ CULTURE		○ SHAVE ○ PUNCH ○ EXCISION ○ OTHER		

BILLING METHOD / INSURANCE INFORMATION

BILLING METHOD:

○ INSURANCE
○ MEDICARE
○ MEDICAID
○ PATIENT
○ PHYSICIAN

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURED NAME / RELATIONSHIP TO INSURED: ○ Self ○ Spouse ○ Dependent	INSURED NAME / RELATIONSHIP TO INSURED: ○ Self ○ Spouse ○ Dependent
INSURANCE NAME	INSURANCE NAME
INSURANCE PHONE	INSURANCE PHONE
INSURANCE ADDRESS	INSURANCE ADDRESS
CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE
EMPLOYER NAME	EMPLOYER NAME
SUBSCRIBER DOB: / / / MEMBER ID# / GROUP/CONTRACT #	SUBSCRIBER DOB: / / / MEMBER ID# / GROUP/CONTRACT #
MEDICARE # / MEDICAID #	MEDICARE # / MEDICAID #

YELLOW COPY - PHYSICIAN'S COPY

FOR LAB USE ONLY:

A.
Size _____ x _____ x _____
Color _____
Lesion _____
Comments _____

B.
Size _____ x _____ x _____
Color _____
Lesion _____
Comments _____

C.
Size _____ x _____ x _____
Color _____
Lesion _____
Comments _____

D.
Size _____ x _____ x _____
Color _____
Lesion _____
Comments _____

E.
Size _____ x _____ x _____
Color _____
Lesion _____
Comments _____

F.
Size _____ x _____ x _____
Color _____
Lesion _____
Comments _____

ADDITIONAL INFORMATION:

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INSURANCE NAME	INSURANCE NAME
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INSURANCE ADDRESS	INSURANCE ADDRESS
CITY / STATE / ZIP CODE	CITY / STATE / ZIP CODE
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SUBSCRIBER DOB: ___/___/___ / MEMBER ID# / GROUP/CONTRACT #	SUBSCRIBER DOB: ___/___/___ / MEMBER ID# / GROUP/CONTRACT #
MEDICARE # / MEDICAID #	MEDICARE # / MEDICAID #

PHYSICIAN'S COPY