ONE CRANBERRY HILL
SUITE 303
LEXINGTON, MA 02421
Phone: 800-325-7284 Fax: 617-401-4032

Req. 100000

DATE OF PROCEDURE: ______________________

PATIENT INFORMATION

____
Date of Birth

Sex: ☐ Female ☐ Male

____
Name (Last, First, Middle Initial)

____
Address

____
City State ZIP Code

____________________ ____________________
Telephone Number Medical Record Number (Optional)

BILLING INFORMATION

Please attach copy of patient's insurance card

☐ Insurance Information Attached	☐ Insurance not on file, Contact Patient directly to obtain
☐ Client Bill	☐ Please Bill the Patient Directly

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Insurance Company	Insurance Company
Member ID	Member ID
Group Number	Group Number
Insured Name	Insured Name
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent	Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

SPECIMEN INFORMATION

	PROCEDURE TYPE		BIOPSY SITE	CLINICAL IMPRESSION
A	**Fungal Nail** ☐ Standard Nail (PAS) * ☐ Reflex to NextGen/PCR only if Positive ☐ Always add NextGen/PCR ☐ Reflex to Culture if Negative ☐ Nail Removal–Gross Only	**Skin/Tissue** ☐ Excision ☐ Re-Excision ☐ Punch ☐ Shave ☐ Curette		
B	**Fungal Nail** ☐ Standard Nail (PAS) * ☐ Reflex to NextGen/PCR only if Positive ☐ Always add NextGen/PCR ☐ Reflex to Culture if Negative ☐ Nail Removal–Gross Only	**Skin/Tissue** ☐ Excision ☐ Re-Excision ☐ Punch ☐ Shave ☐ Curette		
C	**Fungal Nail** ☐ Standard Nail (PAS) * ☐ Reflex to NextGen/PCR only if Positive ☐ Always add NextGen/PCR ☐ Reflex to Culture if Negative ☐ Nail Removal–Gross Only	**Skin/Tissue** ☐ Excision ☐ Re-Excision ☐ Punch ☐ Shave ☐ Curette		

GMS may also be performed as determined by pathologist.

100000 A	**100000 B**	**100000 C**
Patient Name/Initials:	**Patient Name/Initials:**	**Patient Name/Initials:**
DOB:	**DOB:**	**DOB:**
Site:	**Site:**	**Site:**
To ensure processing, affix completed label to specimen container.	***To ensure processing, affix completed label to specimen container.***	***To ensure processing, affix completed label to specimen container.***

FORWARD ADDITIONAL COPY OF REPORT TO

*Dr. Name (first, last): ______________________________

*Fax: ______________________________

Required information to forward reports

Physician Signature:

____

I certify that I have obtained the required authorization and assignment of benefits for the laboratory to bill when insurance billing has been requested above. Physician authorizes Strata Pathology Services to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient accordingly.