SMA Specialty Medical Lab

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DERMATOLOGY

PATIENT INFORMATION

Last Name | First Name | M.I.

Street Address | Apt# | City | State | ZIP

Phone | SSN | D.O.B. | M ☐ F ☐

INSURANCE INFORMATION

Insurance Name | I.D. # | Group#

☐ Bill Medicare ☐ Bill Medicaid ☐ Bill Patient ☐ Bill Client

SPECIMEN INFORMATION

Date Collected:____/____/_____ Time Collected: _____

Fax results to: _____ ☐ STAT

ICD10 CODES						

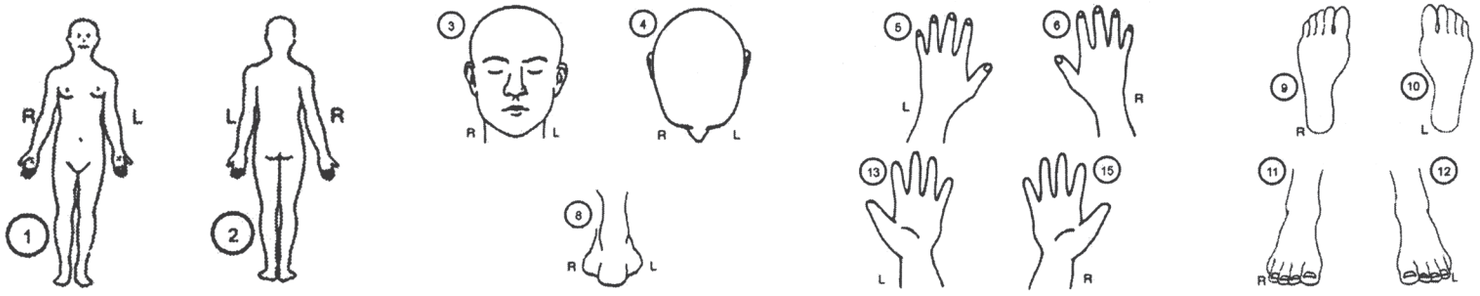
CLINICAL INFORMATION - Check all that apply

	Biopsy Site	Biopsy Method		Collected In	Clinical Description	Clinical Diagnosis
	Jar 1 _____	☐ Punch ☐ Shave ☐ Snap	☐ Curette ☐ Excision Margins_____	☐ Formalin ☐ Other _____		
	Jar 2 _____	☐ Punch ☐ Shave ☐ Snap	☐ Curette ☐ Excision Margins_____	☐ Formalin ☐ Other _____		
	Jar 3 _____	☐ Punch ☐ Shave ☐ Snap	☐ Curette ☐ Excision Margins_____	☐ Formalin ☐ Other _____		
	Jar 4 _____	☐ Punch ☐ Shave ☐ Snap	☐ Curette ☐ Excision Margins_____	☐ Formalin ☐ Other _____		
	Jar 5 _____	☐ Punch ☐ Shave ☐ Snap	☐ Curette ☐ Excision Margins_____	☐ Formalin ☐ Other _____		
	Jar 6 _____	☐ Punch ☐ Shave ☐ Snap	☐ Curette ☐ Excision Margins_____	☐ Formalin ☐ Other _____		

NOTE: Please be sure to label each side collected with the Patient's first and last name. Please use a pencil on frosted end of slides.

ADDITIONAL TEST/COMMENTS

_____ _____
PHYSICIAN'S SIGNATURE (REQUIRED FOR MEDICAID)



PLEASE DO NOT WRITE BELOW THIS LINE. FOR LABORATORY USE ONLY.

GROSS	NOTES
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____