# SMA Specialty Medical Lab

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## HISTOPATHOLOGY

## 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: ____________________

Fasting: ☐ Yes ☐ No Fax results to: ____________________ ☐ STAT

| ICD10 CODES | | | | | | |
|---|---|---|---|---|---|---|

**PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD OR FILL OUT INSURANCE SECTION**

*Clinical History and/or Radiologic findings:

Special Requests:

*Operative Procedure:

Type of Biopsy ☐ Excision ☐ Shave ☐ Punch ☐ Curette ☐ Other

| Biopsy Number | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Anatomic Site of Biopsy | | | | |
| Biopsy Number | 5 | 6 | 7 | 8 |
| Anatomic Site of Biopsy | | | | |

Gross Description:

Physician Signature________________________________DATE___/ ____/ _____

002-3/2023