

Washington University Dermatopathology Center

Cortex | 4320 Forest Park Ave. | Suite 212 | St. Louis, MO 63108 | Tel: (314) 362-5757 | Fax: (314) 362-5701 | www.dermopath.wustl.edu

GENERAL REQUISITION

RUSH

ORDERING PROVIDER - PLEASE SIGN AT THE BOTTOM

Name:	
Address:	
Phone:	Fax:
Copy to Provider A:	Fax:
Copy to Provider B:	Fax:

PATIENT INFORMATION - PLEASE ATTACH COPY OF INSURANCE CARD/DEMOGRAPHIC SHEET

Patient Name (Last, First, MI):	
DOB: ____/____/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
SSN/MRN:	Biopsy Date: ____/____/____

Hair and Nail Specimen

Previous Biopsy

Alopecia Nail

Case # _____

ANATOMICAL SITE	CHECK	CLINICAL DESCRIPTION, DIAGNOSIS, ICD-10 CODE
A)	<input type="checkbox"/> Shave <input type="checkbox"/> AK <input type="checkbox"/> Punch <input type="checkbox"/> BCC <input type="checkbox"/> Excision <input type="checkbox"/> DN <input type="checkbox"/> Curettage <input type="checkbox"/> SCC <input type="checkbox"/> Margins <input type="checkbox"/> SK	DIF <input type="checkbox"/>
B)	<input type="checkbox"/> Shave <input type="checkbox"/> AK <input type="checkbox"/> Punch <input type="checkbox"/> BCC <input type="checkbox"/> Excision <input type="checkbox"/> DN <input type="checkbox"/> Curettage <input type="checkbox"/> SCC <input type="checkbox"/> Margins <input type="checkbox"/> SK	DIF <input type="checkbox"/>
C)	<input type="checkbox"/> Shave <input type="checkbox"/> AK <input type="checkbox"/> Punch <input type="checkbox"/> BCC <input type="checkbox"/> Excision <input type="checkbox"/> DN <input type="checkbox"/> Curettage <input type="checkbox"/> SCC <input type="checkbox"/> Margins <input type="checkbox"/> SK	DIF <input type="checkbox"/>
D)	<input type="checkbox"/> Shave <input type="checkbox"/> AK <input type="checkbox"/> Punch <input type="checkbox"/> BCC <input type="checkbox"/> Excision <input type="checkbox"/> DN <input type="checkbox"/> Curettage <input type="checkbox"/> SCC <input type="checkbox"/> Margins <input type="checkbox"/> SK	DIF <input type="checkbox"/>

LAB USE ONLY - PATHOLOGICAL DIAGNOSIS

REQUISITION

ORDERING PROVIDER'S SIGNATURE: X _____