Washington University Physicians®

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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: ☐ M ☐ F
SSN/MRN:	Biopsy Date: ____ /____ /____

Hair and Nail Specimen

☐ Alopecia ☐ Nail

Previous Biopsy

Case #________________

LAB USE ONLY - GROSS DESCRIPTION

Accession Number

Date Received:

Accessioner:

Received in: Formalin (F) Michel's (M)

A)	☐ F ☐ M
B)	☐ F ☐ M
C)	☐ F ☐ M
D)	☐ F ☐ M

ANATOMICAL SITE	CHECK		CLINICAL DESCRIPTION, DIAGNOSIS, ICD-10 CODE
A)	☐ Shave ☐ Punch ☐ Excision ☐ Curettage ☐ Margins	☐ AK ☐ BCC ☐ DN ☐ SCC ☐ SK	DIF ☐
B)	☐ Shave ☐ Punch ☐ Excision ☐ Curettage ☐ Margins	☐ AK ☐ BCC ☐ DN ☐ SCC ☐ SK	DIF ☐
C)	☐ Shave ☐ Punch ☐ Excision ☐ Curettage ☐ Margins	☐ AK ☐ BCC ☐ DN ☐ SCC ☐ SK	DIF ☐
D)	☐ Shave ☐ Punch ☐ Excision ☐ Curettage ☐ Margins	☐ AK ☐ BCC ☐ DN ☐ SCC ☐ SK	DIF ☐

LAB USE ONLY - PATHOLOGICAL DIAGNOSIS

REQUISITION

ORDERING PROVIDER'S SIGNATURE: X ____________________