Cleveland Clinic
Laboratories

Ver 08/23

Clear Form

DERMATOPATHOLOGY REQUISITION

Please **legibly complete all fields** to ensure timely results.

Patient Information

Patient ID / MRN

Patient Name
First | Middle Initial
Last

Date of Birth ____ / ____ / ____ (month / day / year)

Sex ☐ Male ☐ Female

Patient Address
Address
Apartment, Suite, Other (Optional)
County
City | Zip

☐ Non-US Address
If the patient lives outside of the United States, please provide their home address.

Patient Phone

Billing / Insurance

☐ Client / Institution ☐ Medicare ☐ Insurance ☐ Patient

PLEASE INCLUDE A COPY OF THE PATIENT'S INSURANCE CARD
If a copy of the patient's insurance card is not available, please fill out the information below:

Policy Holder's Name
If different than the patient

Relationship to Patient ☐ Spouse ☐ Dependent ☐ Other:

Medicare HIC Number
If applicable

Medicaid Number
OHIO ONLY | *If applicable*

Insurance Company
If applicable

Policy Number

Group Number

Claims Address
Street
City | State | Zip

Advanced Beneficiary Notice (ABN)?
☐ Yes (attach a copy) ☐ No

Secondary Insurance?
☐ Yes (attach a copy) ☐ No

MEDICAL NECESSITY NOTICE: When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

Clinical Information & Diagnosis Codes

Reason for Testing / Brief Clinical History

ICD-10 Code(s)
1. 2.
3. 4.

Submitter – Client / Organization

Submitter Name

Phone

Fax

Submitter Address
Street
City | State | Zip
Country

Referring Provider

Provider Name
First | Middle Initial
Last

NPI

Email

Phone

☐ **Additional Fax**
Select to fax a second report.

Specimen A

Collection Date ____ / ____ / ____ (month / day / year) **Time** ____:____ ☐ AM ☐ PM

Biopsy Site

Type of Biopsy
☐ Curettings ☐ Punch ☐ Shave
☐ Excision ☐ Punch Excision ☐ Shave Excision
☐ Wide Excision

Date in Fixative ____ / ____ / ____ (month / day / year) **Time** ____:____ ☐ AM ☐ PM

Fixative Type
☐ Formalin ☐ Michel's Media for DIF
☐ Fresh Tissue ☐ Alcohol

Testing to Perform
☐ Gross Examination & Diagnostic Interpretation ☐ Other:

– Additional Tests
☐ FISH for Cutaneous Melanoma *CMFISH*
☐ T-Cell Clonality *TCRB & TCRG* *TCBMDO*
☐ Direct Immunofluorescense
☐ B-Cell Clonality *IGH & IGK* *BCBMDO*
☐ IHC Stain:

Specimen B

Collection Date ____ / ____ / ____ (month / day / year) **Time** ____:____ ☐ AM ☐ PM

Biopsy Site

Type of Biopsy
☐ Curettings ☐ Punch ☐ Shave
☐ Excision ☐ Punch Excision ☐ Shave Excision
☐ Wide Excision

Date in Fixative ____ / ____ / ____ (month / day / year) **Time** ____:____ ☐ AM ☐ PM

Fixative Type
☐ Formalin ☐ Michel's Media for DIF
☐ Fresh Tissue ☐ Alcohol

Testing to Perform
☐ Gross Examination & Diagnostic Interpretation ☐ Other:

– Additional Tests
☐ FISH for Cutaneous Melanoma *CMFISH*
☐ T-Cell Clonality *TCRB & TCRG* *TCBMDO*
☐ Direct Immunofluorescense
☐ B-Cell Clonality *IGH & IGK* *BCBMDO*
☐ IHC Stain:

Specimen Shipping Address Cleveland Clinic Laboratories
2119 East 93rd St • L15 - Pathology & Laboratory Medicine • Cleveland, OH 44106

Client Services 800.628.6816
Fax 216.444.0460

Billing 800.365.3744
Payment terms are **net 30 days**.

Test Directory clevelandcliniclabs.com
Search and view test & specimen information.