

Anatomic Pathology Requisition



Gulf Coast Pathologists
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Example Podiatry

123 N. Main St.
 City, FL
 Ph: (727) 555-5555 F: (727) 555-5555

- Dr. John Doe, DPM - NPI: 1112223334
 Dr. Jane Doe, DPM - NPI: 1112223335

Lab Use Only

ACCESSION NUMBER: _____

- Insurance attached Patient bill Client bill

CLINICAL/TESTING NOTES:

DATE COLLECTED: _____

Time collected: _____ AM/PM Collected by: _____

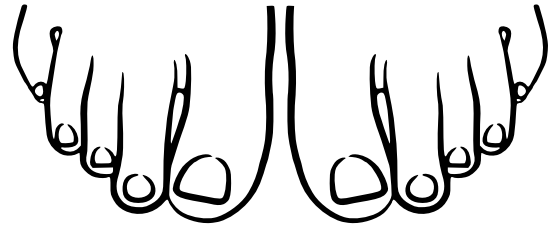
PATIENT NAME: _____

DOB: _____ M / F

Address: _____

NAIL CLIPPING - ONYCHOMYCOSIS (transport **dry** in specimen bag)

| | | |
|---|---|---|
| Specimen A: Digit(s) _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> PAS, GMS, FM (<i>melanin detect</i>) <input type="checkbox"/> PAS, GMS (<i>standard sensitivity</i>) <input type="checkbox"/> PAS (<i>basic sensitivity</i>) | Specimen B: Digit(s) _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> PAS, GMS, FM (<i>melanin detect</i>) <input type="checkbox"/> PAS, GMS (<i>standard sensitivity</i>) <input type="checkbox"/> PAS (<i>basic sensitivity</i>) | Specimen C: Digit(s) _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> PAS, GMS, FM (<i>melanin detect</i>) <input type="checkbox"/> PAS, GMS (<i>standard sensitivity</i>) <input type="checkbox"/> PAS (<i>basic sensitivity</i>) |
|---|---|---|



RIGHT

LEFT

T9 T8 T7 T6 T5

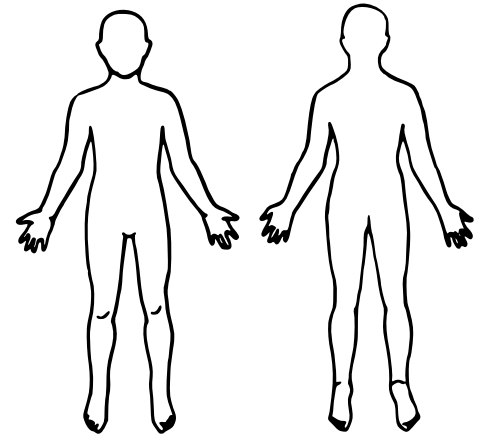
TA T1 T2 T3 T4

NAIL UNIT (transport in **wet** formalin)

| | | |
|---|---|---|
| Specimen A: Digit(s) _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Pigmented streak (<i>melanoma</i>) <input type="checkbox"/> Non-pigmented lesion (<i>verruca</i>) <input type="checkbox"/> PAS (<i>basic sensitivity</i>) <input type="checkbox"/> Other: _____ | Specimen B: Digit(s) _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Pigmented streak (<i>melanoma</i>) <input type="checkbox"/> Non-pigmented lesion (<i>verruca</i>) <input type="checkbox"/> PAS (<i>basic sensitivity</i>) <input type="checkbox"/> Other: _____ | Specimen C: Digit(s) _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Pigmented streak (<i>melanoma</i>) <input type="checkbox"/> Non-pigmented lesion (<i>verruca</i>) <input type="checkbox"/> PAS (<i>basic sensitivity</i>) <input type="checkbox"/> Other: _____ |
|---|---|---|

SKIN AND SOFT TISSUE (transport in **wet** formalin)

| | | | |
|---|---|---|---|
| Specimen A: Site _____ <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Pigmented lesion (<i>melanoma</i>) <input type="checkbox"/> Non-pigmented lesion (<i>verruca</i>) <input type="checkbox"/> Ulceration (<i>vasculitis/malignancy</i>) <input type="checkbox"/> Inflammatory (<i>tophus/abscess</i>) <input type="checkbox"/> Tumor (e.g. cyst, lipoma, sarcoma) <input type="checkbox"/> Dermatitis (<i>tinea/eczematous</i>) <input type="checkbox"/> Other: _____ | Specimen B: Site _____ <input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Shave <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Pigmented lesion (<i>melanoma</i>) <input type="checkbox"/> Non-pigmented lesion (<i>verruca</i>) <input type="checkbox"/> Ulceration (<i>vasculitis/malignancy</i>) <input type="checkbox"/> Inflammatory (<i>tophus/abscess</i>) <input type="checkbox"/> Tumor (e.g. cyst, lipoma, sarcoma) <input type="checkbox"/> Dermatitis (<i>tinea/eczematous</i>) <input type="checkbox"/> Other: _____ |
|---|---|---|---|



BONE (transport in **wet** formalin)

| | |
|---|---|
| Specimen A: Site _____ <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Lesion (e.g. cyst, neoplasm) <input type="checkbox"/> Arthritis (e.g. DJD, exostosis) <input type="checkbox"/> Other: _____ | Specimen B: Site _____ <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Lesion (e.g. cyst, neoplasm) <input type="checkbox"/> Arthritis (e.g. DJD, exostosis) <input type="checkbox"/> Other: _____ |
|---|---|

ASPIRATE (transport **dry** in capped syringe)

| | |
|---|--|
| Specimen A: Site _____ <input type="checkbox"/> Crystal analysis (gout) <input type="checkbox"/> Tumor (ganglion/cyst) Expedited transport of sample needed | Specimen A: Site _____ <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Lesion (e.g. cyst, neoplasm) Expedited transport of sample needed |
|---|--|

Commonly used ICD10 codes (select all that apply)

| | | | |
|--|---|---|--|
| <input type="checkbox"/> Onychomycosis/tinea unguium (B35.1) | <input type="checkbox"/> Plantar wart (B07.0) | <input type="checkbox"/> Type 2 diabetes with foot ulcer (E11.621) | <input type="checkbox"/> Acute osteomyelitis of right ankle/foot (M86.171) |
| <input type="checkbox"/> Dermatophytosis unspecified (B35.9) | <input type="checkbox"/> Tinea pedis (B35.3) | <input type="checkbox"/> Type 2 diabetes w/other skin ulcer (E11.622) | <input type="checkbox"/> Acute osteomyelitis of left ankle/foot (M86.172) |
| <input type="checkbox"/> Nail dystrophy (L60.3) | <input type="checkbox"/> Neoplasm of uncertain behavior (D48.5) | <input type="checkbox"/> Pyoderma gangrenosum (L88) | <input type="checkbox"/> Subacute osteomyelitis unspecified (M86.279) |
| <input type="checkbox"/> Ingrown nail (L60.0) | <input type="checkbox"/> Other specified epidermal thickening (L85.8) | <input type="checkbox"/> L97.____ Non pressure ulcer | <input type="checkbox"/> Chronic osteomyelitis unspecified (M86.379) |
| <input type="checkbox"/> Other nail disorders (L60.8) | <input type="checkbox"/> Other(s): _____ | <input type="checkbox"/> L89.____ Pressure ulcer | <input type="checkbox"/> Other(s): _____ |

PHYSICIAN SIGNATURE

PATIENT SIGNATURE

X _____
PROVIDER AUTHORIZATION

DATE _____

X _____
PATIENT ACKNOWLEDGEMENT

I hereby certify that the tests ordered are medically necessary for patient management.

By signing, I certify my understanding that the testing laboratory will generate a claim to my insurance carrier for the payment of services. I acknowledge that I may be responsible for certain payment(s) as outlined by my individual health insurance policy benefits.