

DERMATOPATHOLOGY REQUISITION



Requesting Clinician/Practitioner

Name	Laboratory Use Only		
Address	Clinician/Practitioner Phone Number		Patient Chart Number
Clinician/Practitioner Billing Number	Health Card Number (HCN)	Version	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Province	Other Province's Registration Number	Date of Birth YYYY / MO / DA
			Patient Telephone Number

Copy to Clinician(s)/Practitioner(s) <i>(fill in all fields)</i>	Patient Last Name <i>(as per Health Card)</i>		
Name	Billing #		
Address	Patient First & Middle Name <i>(as per Health Card)</i>		
Name	Patient Address <i>(including postal code)</i>		
Address	Date of Clinical Procedure YYYY / MO / DA		

Specimen	Anatomic Site & Procedure	Clinical Data (diagnosis or differential diagnosis)
A	<input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/> Re-excision <input type="checkbox"/> Alopecia	
B	<input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/> Re-excision <input type="checkbox"/> Alopecia	
C	<input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/> Re-excision <input type="checkbox"/> Alopecia	
D	<input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/> Re-excision <input type="checkbox"/> Alopecia	
E	<input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/> Re-excision <input type="checkbox"/> Alopecia	
F	<input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/> Re-excision <input type="checkbox"/> Alopecia	
G	<input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/> Re-excision <input type="checkbox"/> Alopecia	
H	<input type="checkbox"/> Excision <input type="checkbox"/> Punch <input type="checkbox"/> Immunofluorescence <input type="checkbox"/> Shave <input type="checkbox"/> Curettage <input type="checkbox"/> Re-excision <input type="checkbox"/> Alopecia	

Total number of containers submitted with this requisition (*maximum 8*) _____ Physician/Practitioner Signature _____

Laboratory Use Only: