



**SPOKANE** (509) 892-2700/(888) 814-6277  
 FAX (509) 892-2740  
**TUKWILA** (425) 646-0922/(877) 288-0922  
 FAX (425) 646-0925  
**RICHLAND** (509) 392-5920/(833) 369-7268  
 FAX (509) 866-5020

LAB NUMBER

<b>CHART #/MRN</b>	<b>DATE OF COLLECTION</b>	<b>SEX</b> <input type="checkbox"/> M <input type="checkbox"/> F
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**PATIENT'S NAME (Last Name, First Name, Middle Initial)**

**ADDRESS**

<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>	<b>PHONE</b>
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<b>PATIENT SOCIAL SECURITY #</b> <small>Please write N/A if SSN is unavailable</small>	<b>PATIENT BIRTHDATE</b>
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**INSURED'S NAME (If other than patient) (Last name, First name, Middle initial)**

**ADDRESS**

<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>	<b>PHONE</b>
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Photomicrograph Requested

**COPY TO:**

First Name	Last Name	Location
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**INSURANCE PLAN OR PROGRAM NAME**

<input type="checkbox"/> Bill Office/ Clinic	<input type="checkbox"/> VA Choice	<input type="checkbox"/> Asuris	<input type="checkbox"/> Molina	<input type="checkbox"/> Aetna
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Group Health	<input type="checkbox"/> Premera	<input type="checkbox"/> CHPW	<input type="checkbox"/> Tricare
<input type="checkbox"/> Medicare	<input type="checkbox"/> Regence of WA	<input type="checkbox"/> First Choice (Group # Req.)		
<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Regence of ID	<input type="checkbox"/> Medicaid (State)		
<input type="checkbox"/> Cigna (Group # Req.)	<input type="checkbox"/> Blue Cross	Other _____		

**INSURANCE NUMBERS MUST BE INCLUDED**      **ATTACH COPY OF MEDICAL INSURANCE**

**ICD-10 CODES:** PLEASE INDICATE DIAGNOSIS CODE(S) RELATING TO THE CURRENT PROCEDURE

TISSUE / BIOPSY / SPECIMEN	LOCATION	COLLECTION
A _____	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	<input type="checkbox"/> EXCISION <input type="checkbox"/> ASPIRATION
B _____	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	<input type="checkbox"/> EXCISION <input type="checkbox"/> ASPIRATION
C _____	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	<input type="checkbox"/> EXCISION <input type="checkbox"/> ASPIRATION

**Previous Tissue to our Lab?**  
 Yes     No

**LAB USE**

DATE RECEIVED \_\_\_\_\_

BILLING CODES \_\_\_\_\_

PREP \_\_\_\_\_

**CLINICAL INFORMATION:**

**SPECIMEN SKIN**  
 A B C  
   PIGMENTED LESION (Rule out melanoma)  
   NON-PIGMENTED LESION (Verrucous/Carcinoma)  
   DERMATITIS (Eczematous/Tinea)  
   ULCERATION (Malignancy/Vasculitis)  
   OTHER \_\_\_\_\_

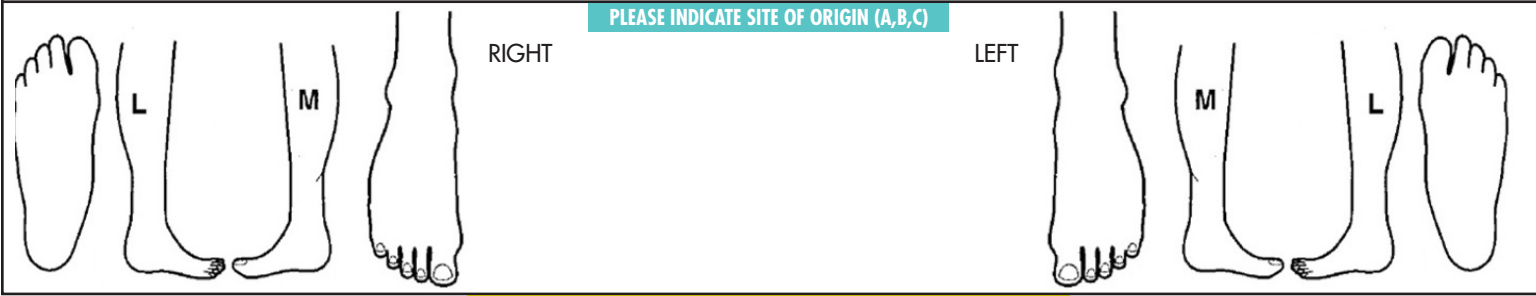
**SPECIMEN SOFT TISSUE**  
 A B C  
   MASS (Ganglion/Lipoma/Sarcoma)  
   INFLAMMATORY (Tophus/Abscess)  
   OTHER \_\_\_\_\_  
   Check for Crystals

**SPECIMEN BONE**  
 A B C  
   ARTHRITIS (HAV/Hammer Toe/DJD/RA)  
   LYTIC/DESTRUCTIVE (Osteomyelitis/Neoplasm)  
   OTHER \_\_\_\_\_  
   Check Margins

**SPECIMEN NAIL UNIT**  
 A B C  
   NAIL UNIT DYSTROPHY (Onychomycosis/Trauma)  
   HISTOPATHOLOGY with Special Stain (PAS) for Fungus

**RULE OUT NEOPLASIA**  
   PIGMENTED STREAK/LESION (R/O Melanoma)  
   NON-PIGMENTED LESION (Verrucous/Carcinoma)

**ADDITIONAL CLINICAL INFORMATION (size, color, shape, distribution, duration, drugs, history of change etc.)**



**AFFIX LABEL(S) TO SPECIMEN CONTAINER(S) WITH FULL PATIENT NAME AND SPECIMEN SITE**