Mid-Florida Pathology

For specimen pick up, please call 352-308-8903

Date of collection: _____ Time of collection: _____

PATIENT INFORMATION

	First	*Last*
Name		

	Month Day Year
Sex	Birth Date

Social Security#   Hosp./Clinic#

Street Address/Apt.#

City   State   Zip

Phone *(Home)*   *(Work)*

PHYSICIAN INFORMATION

PRIMARY INSURANCE ☐ Self Pay ☐ Insurance

Please include a copy of insurance card and patient ID.

Insurance Company

Subscriber/Member#   Group#

Claim Address

City   State   Zip

SECONDARY INSURANCE ☐ None

Insurance Company

Subscriber/Member#   Group#

Claim Address

City   State   Zip

SKIN BIOPSY / EXCISION REQUISITION

	Site:	Check:	Margins?	Clinical Diagnosis / Previous Biopsy Diagnosis
A		☐ Excision ☐ Shave ☐ Punch ☐ Primary Excision	☐	
B		☐ Excision ☐ Shave ☐ Punch ☐ Primary Excision	☐	
C		☐ Excision ☐ Shave ☐ Punch ☐ Primary Excision	☐	
D		☐ Excision ☐ Shave ☐ Punch ☐ Primary Excision	☐	
E		☐ Excision ☐ Shave ☐ Punch ☐ Primary Excision	☐	
F		☐ Excision ☐ Shave ☐ Punch ☐ Primary Excision	☐	

Lab Use Only / Gross:

A:	B:	C:
D:	E:	F:

Pathologist Use Only:

A:	B:	C:
D:	E:	F: