Charlottesville Pathology Associates
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DERMATOPATHOLOGY CONSULTATION REQUEST

INFORMATION IN BLUE IS REQUIRED.

Billing Information(Check box(es) & provide billing information below or attach insurance card)
Bill To: ☐ Primary Insurance ☐ Patient (Self Pay) ☐ Other (Indicate below)
☐ Secondary Insurance ☐ Doctor /Group

PRIMARY
Insurance Company
Insurance Company Address
Policy No. | Group No.
Policyholder's Name
Policyholder's Address
Place of Employment

COPY OF INSURANCE CARD

SECONDARY
Insurance Company
Insurance Company Address
Policy No. | Group No.
Policyholder's Name
Policyholder's Address
Place of Employment

Patient Name (Last, First, MI)
Address

PATIENT IDENTIFICATION LABEL

Social Security # | Phone #
D.O.B. | Sex | Date
Doctor | Office Chart #

Physician's Signature

S.P. Accession No.

CC of Report To
Name & Phone #

LOCATION
☐ Private Office
☐ MJ- OSC
☐ Other _____

Intraoperative Consult
☐ Yes ☐ No

Previous Pathology Accession #'s

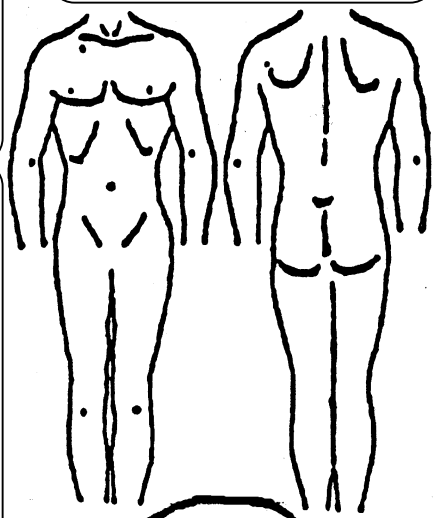
Specimen Type
☐ **Biopsy** ☐ **Excision**
☐ **Other:** _____

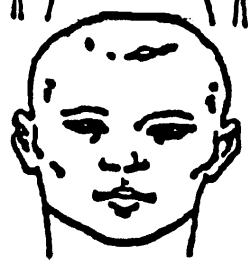
Clinical History:
(REQUIRED INFO.)

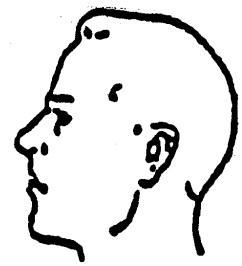
ICD9 Codes

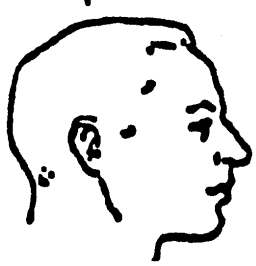
LMP:

Diagram/Orientation/
Special Instructions:









SPECIMEN SOURCE (REQUIRED INFO.)

①	⑦
②	⑧
③	⑨
④	⑩
⑤	⑪
⑥	⑫

FOR PATHOLOGY USE ONLY