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PROPATH
A Sonic Healthcare Anatomic Pathology Practice

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REFERRED BY

PATIENT INFORMATION - PLEASE PRINT: PATIENT NAME (LAST) (FIRST) (M.I.)

ADDRESS | APT#

CITY | STATE | ZIP

(AREA CODE) PHONE | BIRTH DATE | SEX

PATIENT S.S. # | PATIENT I.D.#

Is the patient in a Skilled Nursing Facility (SNF)? If yes, please write the name and address of the SNF below.

BILL TO: ☐ **Account** ☐ **Patient (Self Pay)** ☐ **Medicare** ☐ **Medicaid** ☐ **Insurance** ⁎**Please submit a copy of ID card (front and back)**

INSURANCE COMPANY NAME (attach card) | EMPLOYER NAME

NAME OF INSURED | POLICY / MEMBER ID # | GROUP #

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

MAIL CLAIM TO

ADDRESS

CITY/STATE/ZIP

Referring Physician: _____ NPI: _____

DATE COLLECTED

Send Duplicate Report to:
Name: _____
Address: _____
City/State/Zip: _____

DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

DIAGNOSIS CODE	DIAGNOSIS CODE	DIAGNOSIS CODE

PHYSICIAN ACKNOWLEDGEMENT (Required)

Physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient. ***Medicare Patients: The Advance Beneficiary Notice, if required, must be completed, signed by the patient and attached.***

Physician's Signature: _____ **Date Ordered:** _____

PODIATRIC PATHOLOGY REQUISITION

Specimens for Fungus: *(submit dry in a "nail bag" or in formalin)*

1) Nail Specimen Source / Site: _____ *(or mark on diagram)*
☐ Nail Examination⁎ (PAS)

2) Nail Specimen Source / Site: _____ *(or mark on diagram)*
☐ Nail Examination⁎ (PAS)

⁎*Includes examination by histopathology and PAS stain*

Specimens for Biopsy: *(submit in formalin)*

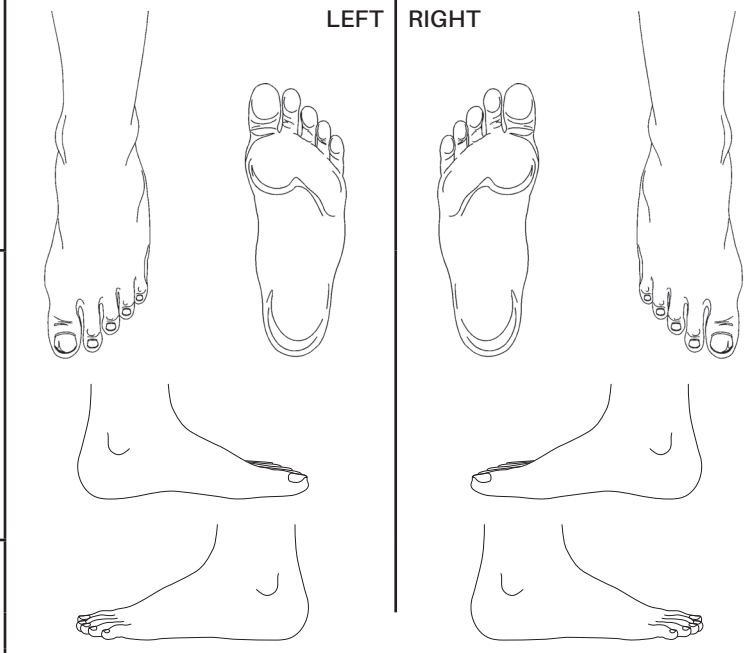
1) Specimen Source / Site: _____ *(or mark on diagram)*
☐ Skin ☐ Nail ☐ Soft Tissue ☐ Bone
☐ Other: _____

2) Specimen Source / Site: _____ *(or mark on diagram)*
☐ Skin ☐ Nail ☐ Soft Tissue ☐ Bone
☐ Other: _____

Clinical History / Impression / Other Info:

☐ Melanoma/Pigmented Lesion/Nevus
☐ Dermatitis/Psoriasis
☐ Verruca
☐ Squamous Cell Carcinoma
☐ Other: _____

LOCATION OF SPECIMEN:



Name _____ Name _____

A C

Name _____ Name _____

B D

NOTE: BE SURE TO LABEL EACH SPECIMEN WITH PATIENT FIRST AND LAST NAME

v12/22

Please include the diagnosis code(s) at the highest level of specificity as documented in the patient medical record for this requisition date of service.