00000001

# RML
REGIONAL MEDICAL LABORATORY

4142 S Mingo Rd. Tulsa, OK 74146 (918) 744-2500
WWW.RMLONLINE.COM (800) 722-8077

☐ CALL
☐ FAX

☐ **STAT**

**Completed by:** ____________________

**PATIENT INFORMATION** Please Provide All Information below **(Name on Requisition MUST Match Name on Specimen EXACTLY!)**

| LAST NAME (Please Print Legibly) FIRST MIDDLE | PATIENT ID# | SEX M☐ F☐ | DATE OF BIRTH [ MM / DD / YYYY ] |
|---|---|---|---|
| PATIENT ADDRESS | CITY | STATE | ZIP CODE | HOME PHONE |
| COLLECTION DATE: | TIME: ☐ A.M. ☐ P.M. | PATIENT MRN. | NAME OF GUARANTOR: |

**REQUESTING PHYSICIAN [Last Name, First Name]**

**Provider signature:** ____________________

**BILLING INFORMATION** (Required)

**BILL:** ☐ **CLIENT/ OFFICE** ☐ **PATIENT/ INSURANCE**

**Complete or provide a photo copy of the patient's insurance card(s)**

| PRIMARY INSURANCE CARRIER | 2nd - INSURANCE CARRIER |
|---|---|
| POLICY/ MEMBER/ MEDICARE NUMBER | 2nd - POLICY/ MEMBER/ MEDICARE NUMBER |
| GROUP NUMBER/ PERSONAL CODE | 2nd - GROUP NUMBER/ PERSONAL CODE |
| POLICY HOLDER | 2nd - POLICY HOLDER |
| EMPLOYER | 2nd - EMPLOYER |

**CONSULTING COPY TO PHYSICIAN(s) [Last Name, First Name]**
(COMPLETE MAILING ADDRESS or FAX NUMBER is REQUIRED to SEND a CONSULT REPORT)

**FOR LAB USE ONLY**
LAB ID:

RCV'D TIME/DATE:

**SPECIMENS RCV'D**

- ☐ Tissue
- ☐ Nail(s)
- ☐ Hair
- ☐ Scrapings
- ☐ Fluid
- ☐ Sterile container, no additive ____
- ☐ Sterile container with moistened gauze ____
- ☐ Sterile container with saline ____
- ☐ 10% buffered formalin container ____
- ☐ DIF: Michel's media or Zeus solution ____
- ☐ ExCell Plus™ container ____
- ☐ eSwab
- ☐ RPMI Preservative ____

9-2019

## DERMATOPATHOLOGY TISSUE EXAM REQUEST – Label should include patient first name, last name and unique ID number (birth date, MRN or requisition number, etc.) and specimen designation or source for multiple specimens

PREVIOUS PATHOLOGY CASE # ____________________

☐ 8090000 HISTOLOGIC PATHOLOGY

| SPECIMEN/SOURCE/SITE | OTHER | CURETTE | EXC | PUNCH | SHAVE BX | SHAVE REMOVAL | CLINICAL IMPRESSION | ICD10 | For Tumor | For Rash | Pigment |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | ☐ | ☐ | ☐ |
| B | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | ☐ | ☐ | ☐ |
| C | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | ☐ | ☐ | ☐ |
| D | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | ☐ | ☐ | ☐ |
| E | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | | | ☐ | ☐ | ☐ |

SPECIAL INSTRUCTIONS

CLINICAL HISTORY

____________________
____________________
____________________
____________________
____________________
____________________

OTHER TESTING

- ☐ 6000130 Acid Fast Bacilli Direct (AFB) ____
- ☐ 6000153 Bacterial (Aerobic) Culture and Stain ____
- ☐ 6000325 Fungus Culture for hair, skin scrapings or nail ____
- ☐ 6000300 Fungus Culture for fluid, tissue or wounds ____
- ☐ Fungal Stain for Onychomycosis/Other ____
- ☐ DIF PANEL ____
- ☐ OTHER ____
- ☐ ____
- ☐ ____
- ☐ ____

Physician authorizes RML to perform all appropriate laboratory services related to this specimen(s) and to bill payor/patient as directed.