LABORATORY MEDICINE CONSULTANTS, LTD.
3059 SOUTH MARYLAND PARKWAY, SUITE 100
LAS VEGAS, NEVADA 89109
PATHOLOGY DEPT: (702) 732-3441

DERMATOPATHOLOGY / O.P. SURGICAL REQUEST FORM

DATE

PATIENT ID #

BAR CODE LABEL HERE

PLEASE BILL:

❑ PATIENT ❑ MEDICARE

❑ PHYSICIAN ❑ INSURANCE

PLEASE ATTACH BILLING INFORMATION

MEDICARE / SS / INS/ #: ______

PATIENT NAME (LAST/FIRST) MI

PATIENT ADDRESS

PATIENT (CITY, STATE, ZIP)

PATIENT SOCIAL SECURITY NUMBER — —

PATIENT DATE OF BIRTH / /

PATIENT PHONE NUMBER (AREA CODE, NUMBER) — —

PATIENT AGE

SEX

DIAGNOSIS (SPECIFY ICD 9 CODES) HIGHEST SPECIFICITY REQUIRED	1	2	3

REFERRING PHYSICIAN AND/OR REFERRING FACILITY

CLINICAL DX: ______

OPERATION / PROCEDURE: ______

SPECIMEN / SITE: ______

ADDITIONAL COPY OF RESULTS TO:	(LAST NAME)	(FIRST NAME)	(FAX NUMBER)

OF PIECES SUBMITTED:

INTERPRETATION REQUESTED:

❑ YES ❑ NO

PLEASE ATTACH PERTINENT BILLING / INSURANCE FORMS

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