Johns Hopkins Dermatopathology & Oral Pathology

Requisition Form – Wet/Fresh Tissue Submission

Surgical Pathology Label / Barcode

600 N. Wolfe Street – Blalock 907 Baltimore, MD 21287
Phone: (877) 321-9444 toll free / (410) 955-3484 Fax: (410) 955-2445

Specimen Collection / Procedure Date: _____

(Required) Submitting/Requesting Physician's Signature:

_____ **Date & Time:**_____

Patient Info. (or place patient label over this section)
History Number / MRN (or SSN):
Last / First / MI:
DOB:
Clinic / Location: ❒ male ❒ female

Please complete the section below in its entirety

Submitting/Requesting Physician		**Other Physician to Receive Report**	
Last / First / Title:	JH Doctor # / NPI:	Last / First / Title:	
City / State / Zip:		Street Address / City / State / Zip:	
Phone / Pager:	Fax:	Phone / Pager:	Fax:

Clinical Description / History

Special Stains/Studies Requested	**Biopsy for alopecia requiring horizontal sections?**	**Immunofluorescence (IF) analysis specimen(s) sent separately?**
	❒ yes ❒ no	❒ yes ❒ no

Biopsy Site [must *exactly* match label on specimen container]	**Procedure**	**Clinical Diagnosis**
1.		
2.		
3.		
4.		

Insurance / Billing Information		**Patient / Guarantor Authorization**
Policy Holder's Name (Last / First / MI):	Relationship to patient:	I acknowledge my responsibility for all charges for these laboratory services requested on my behalf by my physician and authorize the release of information, including medical information, for this and any related claim, to the named insurance company. I also promise to pay for all charges for any of these laboratory services that are not covered or are only partially covered/authorized by my insurance or Health Maintenance Organization.
❒ Medicare #, Letter:	**if Medicare, please list secondary also.	
❒ Blue Shield #, Group, State:	❒ Medical Asst. #:	
❒ Ins. Company:	❒ Copy of insurance card attached	
Policy #:	Plan #:	**Subscriber / Beneficiary Signature**: _____
Group #:	Auth. #:	**Date**: _____

❒ Supplies needed: _____ specimen kits

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