MAWD
MAWD PATHOLOGY GROUP

DERMATOPATHOLOGY REQUISITION

APPLY ID STAMP OR STICKER HERE

2750 CLAY EDWARDS DRIVE, SUITE 420, NORTH KANSAS CITY, MO 64116 (816) 241-3338
(800) 933-6293
Fax (816) 241-6531

CLIENT NAME AND ADDRESS	PATIENT NAME (LAST) (FIRST) (MI)	SEX	DOB

COLLECTION DATE	PATIENT NUMBER	PATIENT SSN

ORDERING PHYSICIAN

COPY REPORT TO:

CC REPORT TO

ADDRESS

CITY STATE ZIP

RESPONSIBLE PARTY & INSURANCE (ATTACH COPIES OF INSURANCE CARDS OR PATIENT DEMOGRAPHIC SHEET)

BILL TO ☐ PATIENT (SELF) ☐ INSURANCE

PT RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

NAME OF INSURED (IF NOT SELF) | INSURED'S SSN:

ADDRESS CITY STATE ZIP

PHONE NUMBER HOME WORK

☐ See Attached:

Attach All Copies of Insurance

CLINICAL INFORMATION

SPECIMEN NUMBER	ANATOMIC SITE	CLINICAL DIAGNOSIS / ICD 9	MARGINS REQUESTED CHECK BOX IF DESIRED	SPECIMEN TYPE
A			☐	☐ Punch ☐ Excision ☐ Shave ☐ Curettage
B			☐	☐ Punch ☐ Excision ☐ Shave ☐ Curettage
C			☐	☐ Punch ☐ Excision ☐ Shave ☐ Curettage
D			☐	☐ Punch ☐ Excision ☐ Shave ☐ Curettage
E			☐	☐ Punch ☐ Excision ☐ Shave ☐ Curettage

ADDITIONAL INFORMATION: