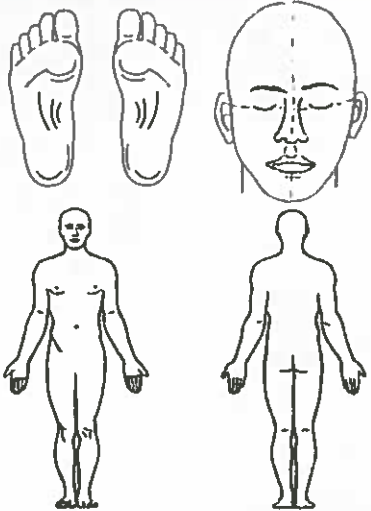










PATIENT INFORMATION				COLLECTION INFORMATION																															
Last Name		First Name		Collection	AM																														
Address		Apt #		Date: ___/___/___	Time: ___:___ PM																														
BILLING INFORMATION				ACCOUNT INFORMATION																															
Name of Insured		City		State																															
Company Name		Zip Code		Phone																															
Street Address		Sex		Age																															
City		DOB		Social Security #																															
State		MR/Chart #:		Zip Code																															
Policy #		Group #		Medicare/ Medicaid #																															
Referral #																																			
RULE OUT / SUSPECTED DIAGNOSIS				MARK SPECIMEN SITE																															
_____ _____ _____ ICD-10 Codes: _____																																			
CLINICAL INFORMATION																																			
_____ _____																																			
HISTOLOGY		HISTOLOGY		MYCOLOGY EVALUATION																															
SPECIMEN(S)		SPECIMEN(S)		For optimal results, collect both formalin, and unfixed specimens. If limited tissue is available, send specimen unfixed. Priority of testing Histology, Culture then KOH																															
JAR	TYPE / SITE	JAR	TYPE / SITE																																
A.	_____	F.	_____	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d4edda;"> <th colspan="3" style="text-align: left;">SPECIMENS</th> <th style="font-size: small;">Histology w/ PAS Stain</th> <th style="font-size: small;">Fungal Culture</th> <th style="font-size: small;">KOH</th> </tr> <tr> <th>JAR</th> <th>Type / Site</th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>A.</td> <td>_____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>B.</td> <td>_____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>C.</td> <td>_____</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		SPECIMENS			Histology w/ PAS Stain	Fungal Culture	KOH	JAR	Type / Site					A.	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B.	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C.	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SPECIMENS			Histology w/ PAS Stain			Fungal Culture	KOH																												
JAR	Type / Site																																		
A.	_____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>																												
B.	_____	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>																												
C.	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																														
B.	_____	G.	_____																																
C.	_____	H.	_____																																
D.	_____	I.	_____																																
E.	_____	J.	_____																																
CYTOLOGY			WOUND CULTURE																																
JAR	TYPE / SITE		<input type="checkbox"/> Wound Culture and Sensitivity (Swab)																																
A.	FNA Site: _____	Size: ___ cm.	JAR	TYPE / SITE																															
B.	FNA Site: _____	Size: ___ cm.	A.	_____																															

Pt. Name: AS 1085	Pt. Name: AS1085	Pt. Name: AS 1085	Pt. Name: AS1085
Site: _____	Site: _____	Site: _____	Site: _____
Jar#: _____ 	Jar#: _____ 	Jar#: _____ 	Jar#: _____ 
Pt. Name: AS 1085	Pt. Name: AS1085	Pt. Name: AS 1085	Pt. Name: AS1085
Site: _____	Site: _____	Site: _____	Site: _____
Jar#: _____ 	Jar#: _____ 	Jar#: _____ 	Jar#: _____ 

Non-Medicare Patients: I hereby authorize Alliance Laboratories of Westchester to furnish my designated insurance carrier the information on this form if necessary for reimbursement. I also authorize benefits to be payable to Alliance Laboratories of Westchester. I understand that I am responsible for any amount not paid by insurance for reasons including, but not limited to, non-authorized services. I permit a copy of this authorization to be used in place of the original.

Patient/Responsible Party Signature: _____