TOPLAB 67-71 East Willow St Millburn, NJ 07041 Ph: 973-250-9898 Fax: 973-200-8087

P10000 **PATHOLOGY**

Practice Information

Ordering Physician: _____

Physican Signature Date

Patient Information

Last Name: _____ First Name: _____

Middle Name: _____ ○ F ○ M DOB: ____/____/_____ Phone: (___) _____

Address: _____ SSN: _____-____-_____

City: _____ State: _____ ZIP: _____ PT ID: _____

Insurance Company: _____

Claim Number: _____ Date of Accident: _____

Diagnosis Codes

Specimen Data

Date Collected: _____/____/____ Time: ____:____ AM/PM

Collector: _____

Fasting: (Circle) YES / No

Billing Information

○ Patient ○ Medicare ○ Insurance ○ Auto Injury

○ Client ○ Medicaid ○ Workers Comp

Relationship

○ Self ○ Spouse ○ Child ○ Other: _____

Specimen 1

Collection Method

○ Biopsy ○ Excision ○ Aspiration

○ Shaving ○ Punch

○ Other: _____

Specimen Location

○ Left ○ Right

○ Back ○ Head ○ Hand

○ Nose ○ Foot ○ Toe

○ Leg ○ Arm ○ Knee

○ Other: _____

Clinical Information

Skin

○ Pigmented Lesion

○ Non-Pigmented Lesion

○ Dermatitis

○ Ulceration

○ Other: _____

Soft Tissue

○ Mass

○ Inflammatory

Bone

○ Arthritis

○ Lytic/Destructive

○ Other: _____

Additional Clinical information

Specimen 2

Collection Method

○ Biopsy ○ Excision ○ Aspiration

○ Shaving ○ Punch

○ Other: _____

Specimen Location

○ Left ○ Right

○ Back ○ Head ○ Hand

○ Nose ○ Foot ○ Toe

○ Leg ○ Arm ○ Knee

○ Other: _____

Clinical Information

Skin

○ Pigmented Lesion

○ Non-Pigmented Lesion

○ Dermatitis

○ Ulceration

○ Other: _____

Soft Tissue

○ Mass

○ Inflammatory

Bone

○ Arthritis

○ Lytic/Destructive

○ Other: _____

Additional Clinical information

Specimen 3

Collection Method

○ Biopsy ○ Excision ○ Aspiration

○ Shaving ○ Punch

○ Other: _____

Specimen Location

○ Left ○ Right

○ Back ○ Head ○ Hand

○ Nose ○ Foot ○ Toe

○ Leg ○ Arm ○ Knee

○ Other: _____

Clinical Information

Skin

○ Pigmented Lesion

○ Non-Pigmented Lesion

○ Dermatitis

○ Ulceration

○ Other: _____

Soft Tissue

○ Mass

○ Inflammatory

Bone

○ Arthritis

○ Lytic/Destructive

○ Other: _____

Additional Clinical information

PATIENT AUTHORIZATION

I certify that I have voluntarily provided a fresh and unadulterated urine specimen for analytical testing. The information on this form and on the label affixed to the specimen cup is accurate. I authorize Toplab to release the results of this testing to the treating authorized healthcare provider or facility. I hereby authorize my insurance plan to be billed and benefits to be paid directly to Toplab for services I received. I acknowledge that Toplab may be an out-of-network provider with my insurer. I am also aware that in some circumstances my insurer will send the payment directly to me. I agree to endorse insurance check and forward it to Toplab within 30 days of receipt. Failure to do so may result in my account being forwarded to Collections and reported to a Credit Bureau. I understand that Toplab may use my specimen and any testing performed on that specimen, for research, development and potential publication purposes, so long as the information has been properly de-identified pursuant to law.

PATIENT SIGNATURE: _____ **DATE:** _____

P10000	P10000	P10000
Name	Name	Name
DOB Specimen 1	DOB Specimen 2	DOB Specimen 3