Biopsy Examination Request

Requesting Doctor:

Name_____

Address_____
City/State/Zip_____
Phone_____
Fax_____

LAHORE HEALTH CARE LAB & RESEARCH CENTER

ISO 9001:2015

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

IMPORTANT- Please complete the information requested below and have the patient sign the informed consent (on a separate paper) prior to processing a biopsy. It will assist us in filing an insurance claim on behalf of your patient.

Patient's Information First_____ Middle _____Last _____ Phone #_____		
Address_____ City_____ State Zip		D.O.B._____Male Female Social Security
	Social Security	Phone #-(___)_____ D.O.B Male Female
Address_____City_____State_____Zip_____		
_____		
_____		
_____ _____	_____ _____	_____ _____

Lesion Location (Use diagram on reverse) _____ Excision Incision _____
History: _____
_____
_____
_____

Clinical Appearance: _____
_____
_____

Radiographic Appearance (Submission of Radiographs desired):_____
_____
_____

Clinical Impression: _____ **Biopsy Date**: _____

Additional Comments and Information: _____
_____

Lab use only Date Received: X-ray received: yes No Lab. No.