



NEW ENGLAND TISSUE ISSUE INC.

SPECIALIZED PATHOLOGY SERVICES WITH A BEDSIDE MANNER

ERIN O'LEARY, MD
TODD VINOVRSKI, MD
CAROLINE WILKEL, MD

508.235.1118 P
508.235.1119 F

NETISSUEISSUE@GMAIL.COM
1822 NORTH MAIN ST., SUITE 302
FALL RIVER, MA 02720
CLIA LICENSE # 22D2015045
TODD VINOVRSKI MD, LABORATORY DIRECTOR

NAME / last / first		DATE OF COLLECTION	DATE OF ACCESSION (lab use only)
ADDRESS / street or box / city /state / zip			ACCESSION # (lab use only)
D.O.B.	SEX M F	TELEPHONE	PRACTICE MR# (optional)

BILL TO (please circle): BC/MA BC/RI MEDICARE BC/PLAN 65 UNH AETNA CIGNA TUFTS SELF PAY/OTHER

PRIMARY INSURANCE (please attach front/back card copy)		SECONDARY INSURANCE	
POLICY HOLDER'S NAME	DOB	POLICY HOLDER'S NAME	DOB
ID/GROUP NUMBERS		ID/GROUP NUMBERS	
BILLING ADDRESS		BILLING ADDRESS	

SPECIMEN DATA		CLINICAL FINDINGS	
1 SITE	<input type="radio"/> PUNCH BIOPSY <input type="radio"/> PUNCH EXCISION (INK) <input type="radio"/> SHAVE BIOPSY <input type="radio"/> SHAVE REMOVAL (INK) <input type="radio"/> EXCISION (INK) <input type="radio"/> CURETTAGE <input type="radio"/> ALOPECIA SECTIONS <input type="radio"/> PAS FUNGAL (NAIL) <input type="radio"/> DIF	<input type="radio"/> NEVUS (ATYPICAL) <input type="radio"/> MELANOMA	PRIOR PATH #
		<input type="radio"/> BCC <input type="radio"/> SCC <input type="radio"/> AK <input type="radio"/> SK <input type="radio"/> FEP <input type="radio"/> DF <input type="radio"/> VV	
GROSS (lab use only) _____x_____x_____cm		SPECIMEN IS: <input type="radio"/> INKED <input type="radio"/> B/S <input type="radio"/> T/S <input type="radio"/> S/S SUBMITTED: <input type="radio"/> ENTIRELY <input type="radio"/> PARTIALLY #_____	
2 SITE	<input type="radio"/> PUNCH BIOPSY <input type="radio"/> PUNCH EXCISION (INK) <input type="radio"/> SHAVE BIOPSY <input type="radio"/> SHAVE REMOVAL (INK) <input type="radio"/> EXCISION (INK) <input type="radio"/> CURETTAGE <input type="radio"/> ALOPECIA SECTIONS <input type="radio"/> PAS FUNGAL (NAIL) <input type="radio"/> DIF	<input type="radio"/> NEVUS (ATYPICAL) <input type="radio"/> MELANOMA	PRIOR PATH #
		<input type="radio"/> BCC <input type="radio"/> SCC <input type="radio"/> AK <input type="radio"/> SK <input type="radio"/> FEP <input type="radio"/> DF <input type="radio"/> VV	
GROSS (lab use only) _____x_____x_____cm		SPECIMEN IS: <input type="radio"/> INKED <input type="radio"/> B/S <input type="radio"/> T/S <input type="radio"/> S/S SUBMITTED: <input type="radio"/> ENTIRELY <input type="radio"/> PARTIALLY #_____	
3 SITE	<input type="radio"/> PUNCH BIOPSY <input type="radio"/> PUNCH EXCISION (INK) <input type="radio"/> SHAVE BIOPSY <input type="radio"/> SHAVE REMOVAL (INK) <input type="radio"/> EXCISION (INK) <input type="radio"/> CURETTAGE <input type="radio"/> ALOPECIA SECTIONS <input type="radio"/> PAS FUNGAL (NAIL) <input type="radio"/> DIF	<input type="radio"/> NEVUS (ATYPICAL) <input type="radio"/> MELANOMA	PRIOR PATH #
		<input type="radio"/> BCC <input type="radio"/> SCC <input type="radio"/> AK <input type="radio"/> SK <input type="radio"/> FEP <input type="radio"/> DF <input type="radio"/> VV	
GROSS (lab use only) _____x_____x_____cm		SPECIMEN IS: <input type="radio"/> INKED <input type="radio"/> B/S <input type="radio"/> T/S <input type="radio"/> S/S SUBMITTED: <input type="radio"/> ENTIRELY <input type="radio"/> PARTIALLY #_____	

SUBMITTING PHYSICIAN _____ SEND COPY OF REPORT TO _____
 SIGNATURE _____ FAX _____
 PHONE _____ FAX _____

SPECIMEN REQUIREMENTS: ALL SPECIMENS ARE TO BE SUBMITTED WITH THIS REQUISITION, IN FIXATIVE CONTAINERS LABELED WITH PATIENT NAME, DOB, AND BIOPSY SITE. PHYSICIAN OFFICES WILL BE CONTACTED WHEN SPECIMENS DO NOT MEET THESE REQUIREMENTS PRIOR TO PROCESSING.