ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Dermatopathology Requisition

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: _____	Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name	Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone
Address	City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*		Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address	Phone	Address	Address
CC Provider ID	CC Submitter ID	Phone	Phone
Clinic Name		Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Tissue Removed by *(Last, First Name)*		Date/Time Received
Location/ Code/ Address (for report)	Collector ID	Phone	Fax

If other than routine: ☐ Priority *(clinical reason required - indicate below under "Clinical Information/History)*
For STAT/critical cases, contact Pathologist directly.

Check the box that applies to the biopsy and provide the information requested below.

ID	Specimen site *(no abbreviations)*	Clinical Diagnosis	Removed Time *(hh:mm*	In Fixative Time *(hh:mm)*	Lesion size *(mm)*	Entire lesion?	Previous biopsy?
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No

Clinical History - Mandatory *(Include clinical diagnosis/differential, anatomic distribution, duration, morphology, any relevant systemic disease, syndrome, exposure and any other important information)*

☐ Alopecia
☐ AK/ BCC/ SCC/ SK
☐ Rash
☐ Immunofluorescence
☐ Dysplastic Nevi
☐ Melanoma
☐ Inflammatory Dermatosis _____
☐ Other _____
Is the patient on any medications? ☐ No ☐ Yes
(if yes, specify) _____

Dictation Code