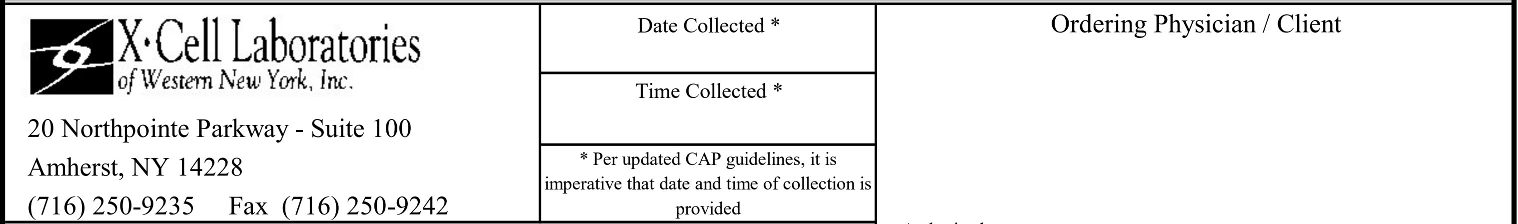
The Area Above This Line Is For Lab Use Only



X·Cell Laboratories of Western New York, Inc.

20 Northpointe Parkway - Suite 100
Amherst, NY 14228
(716) 250-9235   Fax (716) 250-9242

Date Collected *
Time Collected *
* Per updated CAP guidelines, it is imperative that date and time of collection is provided

Ordering Physician / Client

Authorized Signature (required)

PLEASE PRINT ALL INFORMATION CLEARLY

Patient Name	Last		First			
Address						
City State Zip						
D.O.B.		Sex		Phone		

ICD-10 Code (Mandatory)	ICD-10 Code	ICD-10 Code	ICD-10 Code

COPY OF REPORT TO: (**FAX NUMBER MUST BE PROVIDED)**

NAME	FAX #
NAME	FAX #
NAME	FAX #

BILLING

☐ Insurance	☐ Patient	☐ Client

PRIMARY INSURANCE INFORMATION

Insurance Company	
Contract/ID/Policy #	Group #
Name of Insured	

SECONDARY INSURANCE INFORMATION

Insurance Company	
Contract/ID/Policy #	Group #
Name of Insured	

Please label all specimens with the patient's full name and date of birth. Provide patient's clinical history and other relevant information as appropriate. This is a requirement of the NYSDOH.

CLINICAL HISTORY

Duration of clinical presentation / Medications / Prior diagnosis or biopsies:

SKIN ANATOMIC SITE AND LATERALITY	PROCEDURE	DIFFERENTIAL DIAGNOSIS
A		
B		
C		
D		
E		

ADDITIONAL TESTING

☐ Aerobic culture ☐ Anaerobic culture ☐ Fungal culture Source of culture: _______________	☐ Direct Immunofluorescence Source: _______________________	☐ Molecular Test(s):