UC Irvine Dermatopathology Laboratory
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Dermpath use only

PATIENT INFORMATION	PLACE OF SERVICE	PHYSICIAN INFORMATION
First Name: _____ **Last Name:** _____ **MRN:** _____ **Address:** _____ **City:** _____ **State:** ____ **Zip:** _____ **Phone:** _____ **Date of Birth:** _____ **Male [ ] Female [ ]** ☐ **Bill Insurance** ☐ **Bill Medicare** ☐ **Cash Pay** ☐ **Bill Student Health** ☐ **Bill Research:** _____		_____ **Referring Physician/Specialist** **Name** _____ **Phone:** _____ **Fax:** _____

Biopsy Date: _____ **Previous Biopsy Date:** _____

Specimen (A) **Site:** **Clinical Information (please write legibly)**
☐ **Punch**
☐ **Shave**
☐ **Excision**
☐ **Alopecia Protocol**
☐ **Second opinion slide ID#**

Specimen (B) **Site:**
☐ **Punch**
☐ **Shave**
☐ **Excision**
☐ **Alopecia Protocol**
☐ **Second opinion Slide ID#**

Specimen (C) **Site:**
☐ **Punch**
☐ **Shave**
☐ **Excision**
☐ **Alopecia Protocol**
☐ **Second opinion Slide ID#**

Specimen (D) **Site:**
☐ **Punch**
☐ **Shave**
☐ **Excision**
☐ **Alopecia Protocol**
☐ **Second opinion Slide ID#**

Specimen bottle info must correspond to above info

Signature of Physician: _____ **Resident Name:** _____ **Specimen in bottle** _____**Initials**
Please print