UCI Health - Dermatopathology Laboratory
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Dermpath use only

Place Label Here

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

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 (E) **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 ***Form revised 01-2019***