UC DAVIS HEALTH
Department of Dermatology
Dermatopathology Service

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CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

Referring Physician:
Phone:
Fax:

Additional Copies to:
Phone:
Fax:

Patient Last Name	First	MI	Medical Record or Patient ID # or Specimen #	DATE / TIME COLLECTED	INITIALS

Patient SS #	Male	Female	Age	Birthdate
	M ☐	F ☐		

☐ **STAT**

☐ Phone: ( )
☐ Fax: ( )

Patient Address

BILL TO ➔ ☐ Client ☐ Patient* ☐ Insurance

City	State	Zip	Phone #

Attach Copy (Both Sides) of all Insurance Cards

Previous Biopsy:

***NSA Federal requirement to provide patients with an out-of-pocket estimate.**
***Please check if NSA estimate has been provided.** ☐

Additional Comments:

Medicare and Medi-Cal will pay only for tests that meet the Medicare and Medi-Cal coverage criteria and are reasonable and necessary to treat or diagnose an individual patient

Specimen Type

A) Biopsy: ☐ Shave
☐ Punch
☐ Alopecia (trans sect)
☐ Incisional (long sect)
☐ Shave Removal (Check Margins)
☐ Excision (Check Margins)
☐ Shave ☐ Punch ☐ Elliptical
☐ Slide Consultation (attach prev path report)
☐ Direct Immunofluorescence

Site

Clinical Diagnosis/Description

B) Biopsy: ☐ Shave
☐ Punch
☐ Alopecia (trans sect)
☐ Incisional (long sect)
☐ Shave Removal (Check Margins)
☐ Excision (Check Margins)
☐ Shave ☐ Punch ☐ Elliptical
☐ Slide Consultation (attach prev path report)
☐ Direct Immunofluorescence

Site

Clinical Diagnosis/Description

C) Biopsy: ☐ Shave
☐ Punch
☐ Alopecia (trans sect)
☐ Incisional (long sect)
☐ Shave Removal (Check Margins)
☐ Excision (Check Margins)
☐ Shave ☐ Punch ☐ Elliptical
☐ Slide Consultation (attach prev path report)
☐ Direct Immunofluorescence

Site

Clinical Diagnosis/Description

D) Biopsy: ☐ Shave
☐ Punch
☐ Alopecia (trans sect)
☐ Incisional (long sect)
☐ Shave Removal (Check Margins)
☐ Excision (Check Margins)
☐ Shave ☐ Punch ☐ Elliptical
☐ Slide Consultation (attach prev path report)
☐ Direct Immunofluorescence

Site

Clinical Diagnosis/Description

(USE ADDITIONAL SHEETS IF NECESSARY)

LAB USE ONLY: