UC DAVIS DERMATOPATHOLOGY SERVICE

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CLIA ID# 05D1021511 ACCREDITED CA LICENSE ID# CLM 331466 CAP ID# 8058352

SUBMITTING PHYSICIAN:	INSURANCE DATA (OR INCLUDE COPY OF CARD):		
	BILL: Patient* Insurance Other (specify)		
	*Please check if NSA Estimate has been provided		
Phone: Fax:	- Least Grown No. (Estimate rate Best) provided		
ADDITIONAL COPIES TO:			
	Primary carrier: ID/Group#:		
Phone: Fax:	☐ ID/Gloup#. ☐ Billing address:		
PATIENT DATA:			
NAME: (LAST) (FIRST) (M)			
DATE OF BIRTH: MALE FEMALE			
	Secondary carrier:		
SSN#:	ID/Group#:		
ADDRESS & ZIP CODE:	Billing address:		
PHONE:			
(HOME) (WORK)			
DATE OF SERVICE:(TIME)	PREVIOUS BIOPSY?		
SDECIMEN TYPE (CIDCLE)			
SPECIMEN TYPE (CIRCLE) A) BIOPSY SHAVE SITE	CLINICAL DIAGNOSIS / DESCRIPTION		
PUNCH			
☐ALOPECIA (trans sect) ☐INCISIONAL (long sect)			
☐INCISIONAL (long sect) ☐SHAVE REMOVAL (CHECK MARGINS)			
☐INCISIONAL (long sect) ☐SHAVE REMOVAL (CHECK MARGINS) ☐EXCISION (CHECK MARGINS)			
☐INCISIONAL (long sect) ☐SHAVE REMOVAL (CHECK MARGINS) ☐EXCISION (CHECK MARGINS) SHAVE / PUNCH / ELLIPTICAL ☐SLIDE CONSULTATION (attach prev path report)			
☐INCISIONAL (long sect) ☐SHAVE REMOVAL (CHECK MARGINS) ☐EXCISION (CHECK MARGINS) SHAVE / PUNCH / ELLIPTICAL ☐SLIDE CONSULTATION (attach prev path report) ☐DIRECT IMMUNOFLUORESCENCE	CLINICAL DIAGNOSIS / DESCRIPTION		
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(USE ADDITIONAL SHEETS IF NECESSARY)