DERMATOPATHOLOGY NORTHWEST

For lab use only

Date of biopsy: _____

Slide #: _____

Requested by

Clinician Name:	Phone Number:	Fax Number
Clinician Address:		City, State, Zip:
CC: (Name, Phone and Address)		

Direct Case To (check one):

Urgent ☐ ☐ No Preference ☐ Dr. Lantz ☐ Dr. Piepkorn ☐ Dr. Walsh ☐ Dr. Garton ☐ Dr. May

Patient Information:

Patient Last Name:	First Name:	M.I.	Sex: ☐ Male ☐ Female
Date of Birth: *(required)*	SSN:	Phone Number:	
Patient Address:	City, State, Zip:		

Bill To (check one):

☐ Insurance ☐ Patient ☐ Physician (fill in or attach information)

Primary Insurance Name:	Address:
Policy Holder's Name + DOB:	ID and Group Number:

Specimen Information:

	Site	Size and type (shave, punch, excision)
A		
B		
C		
D		
E		

Clinical History & Diagnosis:

	History	Diagnosis	ICD-10CODE
A			
B			
C			
D			
E			

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