

UC DAVIS DERMATOPATHOLOGY SERVICE

DEPARTMENT OF DERMATOLOGY
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CLIA ID# 05D1021511
 CA LICENSE ID#CLM 331466

SUBMITTING PHYSICIAN:		
Phone: _____	Fax: _____	
ADDITIONAL COPIES TO:		
Phone: _____	Fax: _____	
PATIENT DATA:		
NAME: _____	(LAST)	(FIRST) (M)
DATE OF BIRTH: _____	MALE	FEMALE
SSN#: _____		
ADDRESS & ZIP CODE: _____		
PHONE: _____	(HOME)	(WORK)

INSURANCE DATA (OR INCLUDE COPY OF CARD):	
*** (PLEASE SIGN REVERSE)	
BILL (circle): Patient Insurance Other (specify)	
Primary carrier:	
ID/Group#:	
Billing address:	
Patient's relationship to Subscriber: self _____	
Secondary carrier:	
ID/Group#:	
Billing address:	
Patient's relationship to Subscriber: self _____	

DATE OF SERVICE: _____ (TIME)

PREVIOUS BIOPSY? _____

SPECIMEN TYPE (CIRCLE)

A) BIOPSY SHAVE PUNCH ALOPECIA (trans sect) INCISIONAL (long sect) SHAVE REMOVAL (CHECK MARGINS) EXCISION (CHECK MARGINS) PUNCH / ELLIPTICAL SLIDE CONSULTATION DIRECT IMMUNOFLUORESCENCE	SITE	CLINICAL DIAGNOSIS / DESCRIPTION
B) BIOPSY SHAVE PUNCH ALOPECIA (trans sect) INCISIONAL (long sect) SHAVE REMOVAL (CHECK MARGINS) EXCISION (CHECK MARGINS) PUNCH / ELLIPTICAL SLIDE CONSULTATION DIRECT IMMUNOFLUORESCENCE	SITE	CLINICAL DIAGNOSIS / DESCRIPTION
C) BIOPSY SHAVE PUNCH ALOPECIA (trans sect) INCISIONAL (long sect) SHAVE REMOVAL (CHECK MARGINS) EXCISION (CHECK MARGINS) PUNCH / ELLIPTICAL SLIDE CONSULTATION DIRECT IMMUNOFLUORESCENCE	SITE	CLINICAL DIAGNOSIS / DESCRIPTION
D) BIOPSY SHAVE PUNCH ALOPECIA (trans sect) INCISIONAL (long sect) SHAVE REMOVAL (CHECK MARGINS) EXCISION (CHECK MARGINS) PUNCH / ELLIPTICAL SLIDE CONSULTATION DIRECT IMMUNOFLUORESCENCE	SITE	CLINICAL DIAGNOSIS / DESCRIPTION

(USE ADDITIONAL SHEETS IF NECESSARY)

LAB USE ONLY: