

Biopsy Date:

A.W. Dermatopathology Service

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Board-Certified Dermatopathologists

Physician:


Patient: Last First MI SSN: Sex: M F DOB:

Address: Street City: State: Zip code: Tel:

Race: W B H A Previous biopsy? Y N If yes, diagnosis & case #:

Billing Medicare Medicaid Insurance Patient Relationship to insured: self spouse child others

Please supply a copy of patient's insurance & demographic card.

| Biopsy site: | <input type="checkbox"/> front <input type="checkbox"/> back | biopsy type | Clinical diagnosis | Clinical info & description |
|--------------|---|-------------|--------------------|-----------------------------|
| #1 |  | S P E ReE C | | |
| #2 | | S P E ReE C | | |
| #3 | | S P E ReE C | | |
| #4 | | S P E ReE C | | |
| #5 | | S P E ReE C | | |



S: shave. P: punch. E: excision. ReE: re-excision, C: curettage.

For direct immunofluorescence study: lesional peri-lesional sun-exposed non-exposed. Use Michel's medium and keep in refrigerator.