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UCSF DERMATOPATHOLOGY AND ORAL PATHOLOGY SERVICE

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Website: http://dermpath.ucsf.edu Email: info@dermpath.us
CLIA ID # 05D0669292

SUBMITTING CLINICIAN: (PLEASE PRINT)

(Clinician Name)

(Address)

(City, State, Zip)

(Phone) (Fax)

SEND COPIES TO: (PLEASE INCLUDE ADDRESS, PHONE AND FAX NO.)

PATIENT INFORMATION – REQUIRED

NAME (FIRST) (LAST)

DATE OF BIRTH

GENDER ☐ Male ☐ Female ☐ Other: _____

PATIENT ADDRESS (NO PO BOX)

CITY, STATE, ZIP CODE

PHONE NUMBER

DATE OF SERVICE: _____

YOUR PATIENT ACCT NO.: _____

PLACE OF SERVICE: (PLEASE CHECK ONE)

☐ Clinician office (11)
☐ Hospital inpatient (21) *Name* _____
☐ Hospital outpatient (22) *Name* _____
☐ Other _____

BILLING INFORMATION: (PLEASE CHECK ONE)

☐ Bill insurance *(Attach copy of card)*
☐ Bill patient
☐ Bill other *(Attach information)*

SPECIMEN TYPE (CHECK ONE)	**FINDINGS & INSTRUCTIONS** (USE EXTRA SHEETS FOR ADDITIONAL SPECIMENS)
SPECIMEN A: ☐ Punch ☐ Shave ☐ Excision ☐ Incision ☐ Alopecia Sections ☐ Slide Consult ☐ Direct IF (Skin/Mucosa) ☐ Indirect IF (Serum)	**SITE:** **CLINICAL FINDINGS:**
SPECIMEN B: ☐ Punch ☐ Shave ☐ Excision ☐ Incision ☐ Alopecia Sections ☐ Slide Consult ☐ Direct IF (Skin/Mucosa) ☐ Indirect IF (Serum)	**SITE:** **CLINICAL FINDINGS:**
SPECIMEN C: ☐ Punch ☐ Shave ☐ Excision ☐ Incision ☐ Alopecia Sections ☐ Slide Consult ☐ Direct IF (Skin/Mucosa) ☐ Indirect IF (Serum)	**SITE:** **CLINICAL FINDINGS:**

510-006 (Rev. 08/15) WorkflowOne WHITE – DERMAPATH YELLOW - REFERRING PHYSICIAN

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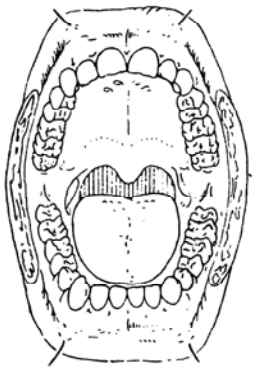
For Oral Pathology Specimens Only

PATIENT INFORMATION - REQUIRED		
Name: (First) (Last)		
Date of Birth:	**Date Of Service:**	**Requisition No.:**



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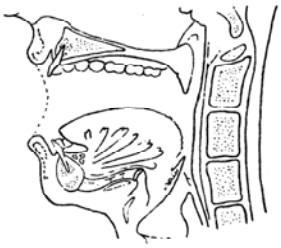

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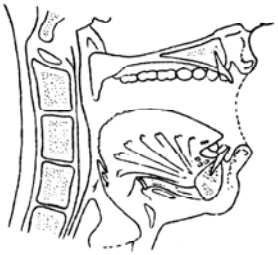

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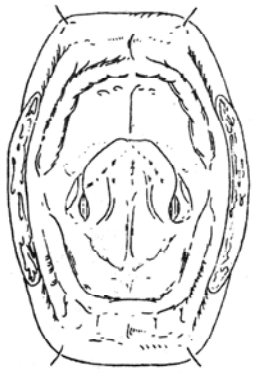

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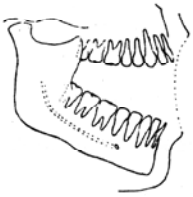

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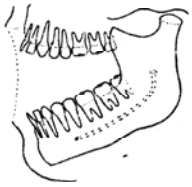

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