OHSU SKIN BIOPSY REQUEST

Dermatopathology/Immunofluorescence
Oregon Health & Science University
Center for Health & Healing
3303 SW Bond Avenue
Mail Code: CH5D
Portland, Oregon 97239-4501
For Lab Results: (503) 494-5245
FAX: (503) 494-4957
E-Mail: Dermpath@OHSU.edu
Web: www.ohsu.edu/dermpath

LABEL

BX date:_____ Phone: _____

Requesting Provider _____

Authorization #:_____

Dermatopathology Use Only

If patient has insurance, please fill out information below:
☐ Patient/Insurance ☐ Requesting Physician

REQUIRED PATIENT/INSURANCE INFORMATION

Patient _____
Last First MI DOB SSN

Sex ☐ Female ☐ Male

Patient Address: _____
Street or PO Box City State Zip Home Phone

Guarantor _____
Last First MI DOB SSN

Guarantor Address: _____
Street or PO Box City State Zip Home Phone

Subscriber/Insured: _____

PLEASE ATTACH COPY OF INSURANCE CARD

Insurance Name:_____ Employer: _____

Insurance Address: _____
Street or PO Box City State Zip Phone

Policy or Insurance ID:_____ Group #_____

☐ INITIAL INTERPRETATION ☐ SLIDE CONSULTATION ☐ SPLIT SKIN ☐ DIRECT IF ☐ INDIRECT IF

SPECIMEN A Biopsy Site (lesional, perilesional) _____ Method (circle one): (Punch, Incision, Excision, Shave)

Clinical History & Impression: _____

DDX: _____ ☐ Rash ICD: _____

SPECIMEN B Biopsy Site (lesional, perilesional) _____ Method (circle one): (Punch, Incision, Excision, Shave)

Clinical History & Impression: _____

DDX:_____ ☐ Rash ICD: _____

SPECIMEN C Biopsy Site (lesional, perilesional) _____ Method (circle one): (Punch, Incision, Excision, Shave)

Clinical History & Impression: _____

DDX:_____ ☐ Rash ICD: _____

For additional specimens, please use a second form.

☐ 88304 _____ ☐ 88313 _____ ☐ 88342 _____
☐ 88305 _____ ☐ 88321 _____
☐ 88312 _____ ☐ 88323 _____

SkinBioRqst 04-28-17 OFFICE COPY

OHSU