UFHealth	1
PATHOLOGY LABORATORIES	

Practice name:	
Address:	
E-mail:	
E-mail:	

ALL ORANGE AREAS ARE REQUIRED.	Phone:Fax:		
Patient information	Specimen information: Dermatopathology		
Name (last, first, middle initial): Sex: Male Female	P: Punch / S: Shave / E: Excision		
	Biopsy Site/Clinical Diagnosis	Margins?	
Date of birth (MM/DD/YYYY):	P S E A		
Medical record/Patient ID#:			
Place of service: ☐ Hospital inpatient ☐ Hospital outpatient ☐ Office/Non-hospital	P S E B	. 🗆	
Billing information	P S E C		
Along with this requisition, you MUST include copies of: • The patient's demographics sheet;			
Both sides of the patient's insurance card(s); andAny secondary insurance information (if applicable).	P S E D	_ 🗆	
Provider information	P S E E		
Ordering physician:			
Phone: Fax:	P S E F		
Ordering physician NPI #:		. 7	
Duplicate report sent to:	P S E G		
Duplicate report fax:			
Clinical history/ICD-10:	P S E H		
	Immunofluorescence (direct) (Michel's fixative required): (indicate above)		
	Consultation on prepared slides:		
	Specimen notes/instructions		
		9	
	Molecular studies		
	B-cell clonality:		
	Melanoma molecular studies	R. 9/2	
Collection date: Time: A.M./P.M.	BRAF mutation analysis:	Revised 9/21/2016	