

PLEASE ATTACH COPY OF FRONT AND BACK OF PATIENT'S INSURANCE CARD OR DEMOGRAPHIC SHEET

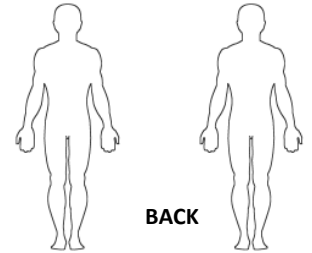
PATIENT INFORMATION

DERMATOLOGY TISSUE EXAMINATION

LAST NAME		FIRST NAME		MIDDLE INITIAL	DATE OF BIRTH
SOCIAL SECURITY NO.	GENDER	MARITAL STATUS	PHONE NUMBER	MRN or CHART NO.	
HOME ADDRESS			CITY	STATE	ZIP
ORDERING PHYSICIAN			COPY TO PHYSICIAN		
CLINICAL HISTORY/ DIAGNOSIS (REQUIRED)					

SPECIMEN INFORMATION

MARK AREA FROM WHICH SPECIMEN WAS REMOVED. DESCRIBE SOURCE IN AREA BELOW.



DATE OF COLLECTION	TIME OF COLLECTION	AM PM	TIME IN FORMALIN (if different from time of collection)	AM PM
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USE EXTRA SHEETS IF MORE THAN 5 SPECIMENS

#	SPECIMEN SITE	Circle: Right Left	SPECIMEN TYPE (Circle) SHAVE ALOPECIA EXCISION PUNCH ____mm OTHER	IMPRESSION
Circle (if applicable) ROUTINE (in Formalin) DIF (Michel's Fixative) CHECK MARGINS				
#	SPECIMEN SITE	Circle: Right Left	SPECIMEN TYPE (Circle) SHAVE ALOPECIA EXCISION PUNCH ____mm OTHER	IMPRESSION
Circle (if applicable) ROUTINE (in Formalin) DIF (Michel's Fixative) CHECK MARGINS				
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