OHSU SKIN BIOPSY REQUEST						
Oregon Health & Science University Center for Health & Healing 1, 5th Floor 3303 S Bond Avenue	LABEL			Dermatopathology Use Only		
Mail Code: CH5D Portland, Oregon 97239-4501 For Lab Results: (503) 494-5245 FAX: (503) 494-4957	BX date:Phone: Requesting Provider:			_		
E-Mail: Dermpath@OHSU.edu	Fax:			If patient has insurance, p below: Patient/Insurance	olease fill out information Requesting Physician	
	REQUIRED PATIEN	NT/INSURANCE INFORM	ATION			
Patient						
Last Sex Female Male Patient Address:	First	MI	DOB		SSN	
Street or PO Box	City	State	•	Zip	Home Phone	
Guarantor	First	MI	DOB		SSN	
			505		3311	
Guarantor Address: Street or PO Box	City	State	•	Zip	Home Phone	
Subscriber/Insured:						
PLEASE ATTACH COPY OF INSURAN	CE CARD					
Insurance Name:		Employer:			_	
Insurance Address:						
Street or PO Box	City	State		Zip	Phone	
Policy or Insurance ID:		Group #				
INITIAL INTERPRETATION	SLIDE CONSULTATION	SPLIT SK	IN [DIRECT IF	☐ INDIRECT IF	
SPECIMEN A Biopsy Site (lesional, perile Clinical History & Impression:	esional)		Meth	nod (circle one): (Punch, Inc	cision, Excision, Shave)	
DDX:			_ Ras	h ICD:		
SPECIMEN B Biopsy Site (lesional, perile Clinical History & Impression:	esional)		Meth	nod (circle one): (Punch, Inc	cision, Excision, Shave)	
DDX:			Rasl	n ICD:		
SPECIMEN C Biopsy Site (lesional, perilesi Clinical History & Impression:	onal)		Meth ——	ood (circle one): (Punch, Inc	cision, Excision, Shave)	
DDX:			_ Rasł	n ICD:		
For additional specimens, please use a second form. SkinBioRqst 04-28-17 OFFICE COPY	88304 88305 88312	88313 88321 88323		88342		
					OHSU	