# OHSU Skin Biopsy Request

**Dermatopathology/Immunofluorescence**
Oregon Health Science University
Center for Health & Healing
3303 SW Bond Avenue
Portland, Oregon 97239-4501

For Lab Results: (503) 494-5245
Fax: (503) 494-4957

E-Mail: Dermpath@OHSU.edu

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**REQUIRED PATIENT/INSURANCE INFORMATION**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>DOB</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Female</td>
<td>Male</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Patient Address:</td>
<td>Street or PO Box</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td>Home Phone</td>
</tr>
<tr>
<td>Guarantor</td>
<td>Last</td>
<td>First</td>
<td>MI</td>
<td>DOB</td>
<td>SSN</td>
</tr>
<tr>
<td>Guarantor Address:</td>
<td>Street or PO Box</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td>Home Phone</td>
</tr>
<tr>
<td>Subscriber/Insured:</td>
<td></td>
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</tbody>
</table>

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**INITIAL INTERPRETATION**

**SLIDE CONSULTATION**

**SPECIMEN A**
- Biopsy Site (lesional, perilesional): ___________________________
- Method (Punch, Incision, Excision, Shave):

**Clinical History & Impression:**

**DDX:** ___________________________  ICD 9: [ ] Rash [ ] 239.2 [ ] Other: [ ]

**SPECIMEN B**
- Biopsy Site (lesional, perilesional): ___________________________
- Method (Punch, Incision, Excision, Shave):

**Clinical History & Impression:**

**DDX:** ___________________________  ICD 9: [ ] Rash [ ] 239.2 [ ] Other: [ ]

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**SPECIMEN C**
- Biopsy Site (lesional, perilesional): ___________________________
- Method (Punch, Incision, Excision, Shave):

**Clinical History & Impression:**

**DDX:** ___________________________  ICD 9: [ ] Rash [ ] 239.2 [ ] Other: [ ]

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For additional specimens, please use a second form.

| 88304 | 88313 | 88342 |
| 88305 | 88321 |     |

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**Authorization #:_______________________________**

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**Patient/Insurance | Requesting Physician**

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**Patient Address:** _______________________________________________________________________________________________________

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**Guarantor Address:** _______________________________________________________________________________________________________

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**Subscriber/Insured:** _______________________________________________________________________________________________________

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**Insurance Name:** __________________________________________  Employer: __________________________________________

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**Insurance Address:** _______________________________________________________________________________________________________

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**Policy or Insurance ID:** ______________________________________  Group #: __________________________

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**PLEASE ATTACH COPY OF INSURANCE CARD**

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**Authorization #:_______________________________**

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**Patient/Insurance | Requesting Physician**

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**Patient Address:** _______________________________________________________________________________________________________

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**Guarantor Address:** _______________________________________________________________________________________________________

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**Subscriber/Insured:** _______________________________________________________________________________________________________

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**Insurance Name:** __________________________________________  Employer: __________________________________________

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**Insurance Address:** _______________________________________________________________________________________________________

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**Policy or Insurance ID:** ______________________________________  Group #: __________________________