

UC SAN DIEGO DERMATOPATHOLOGY LABORATORY

DEPARTMENT OF DERMATOLOGY

8899 UNIVERSITY CENTER LANE SUITE 350

SAN DIEGO, CA 92122-0975

TEL: 858-657-1285

FAX: 858-657-1610



Brian Hinds, MD

bhinds@ucsd.edu

CLINICAL PRACTICE LOCATION:	ORDERING PROVIDER:	DATE OF SERVICE:
ADDITIONAL COPIES TO:	FAX:	
PATIENT NAME:	DATE OF BIRTH:	GENDER:
SSN# or MRN:		

- Please attach a copy of the patient's insurance (face sheet or insurance card)
- Please attach the relevant clinical history either using an internal biopsy requisition form from your clinic or by utilizing the form below.

PLEASE CALL OUR COURIER (JIM) AT 858-775-2110 FOR SPECIMEN PICK-UP

<p>A) <input type="checkbox"/> PUNCH BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISION <u>OR</u> OTHER/SPECIFY:</p> <p>ANATOMICAL SITE: _____</p> <p>CLINICAL DIAGNOSIS / DESCRIPTION: _____</p> <p>_____</p>
<p>B) <input type="checkbox"/> PUNCH BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> SLIDE CONSULTATION <u>OR</u> OTHER/SPECIFY:</p> <p>ANATOMICAL SITE: _____</p> <p>CLINICAL DIAGNOSIS / DESCRIPTION: _____</p> <p>_____</p>
<p>C) <input type="checkbox"/> PUNCH BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISION <u>OR</u> OTHER/SPECIFY:</p> <p>ANATOMICAL SITE: _____</p> <p>CLINICAL DIAGNOSIS / DESCRIPTION: _____</p> <p>_____</p>
<p>D) <input type="checkbox"/> PUNCH BX <input type="checkbox"/> SHAVE BX <input type="checkbox"/> EXCISION <u>OR</u> OTHER/SPECIFY:</p> <p>ANATOMICAL SITE: _____</p> <p>CLINICAL DIAGNOSIS / DESCRIPTION: _____</p> <p>_____</p>

PLEASE SEND ANY ADDITIONAL OR SUPPORTING INFORMATION VIA FAX: 858-657-1610

If questions remain, please feel free to contact our Dermatopathology Coordinator for assistance:

Jennymelva Moral, Administrative II

858-657-1285

j1moral@ucsd.edu

FOR OFFICIAL UCSD DERMATOPATHOLOGY LABORATORY USE ONLY:

RECEIVED DATE: _____

UCSD MRN: _____