

**Dermatopathology Requisition**

UF Health Dermatology - Springhill  
4037 NW 86th Terrace, Gainesville, FL 32606



**Physician/Client Information**

**Complete for All Patients**

Patient Name: (Last) (First) (M.I.) Patient Phone #: Date of Birth: / / Sex: M F

Street Address: City: State: Zip: Patient ID #:

Billing Type:  Global  Client  PC Only  TC Only Bill to:  Commercial Ins.  Patient  Medicare  Medicaid Fax Duplicate Report To: (Provider Name & Fax #)

**Complete to Bill Third Party**

Primary Insurance Name: Address: City: State: Zip:

ID/Member #: Group #: Responsible Party/Insured Employer:

Place of Service:  Clinic  Ambulatory Surg.  Hosp. Inpatient  Hosp. Outpatient Secondary Insurance?  Yes  No If yes, please attach information. Patient Relationship to Policy Holder?  Self  Spouse  Dependent Policy Holder's Date of Birth: / /

**Ordering Physician:**

ICD-9 ICD-9 ICD-9 ICD-9

Collection Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Special Requests:

**Patient History/Special Requests:**

\_\_\_\_\_

	Biopsy Site	Margins	Clinical Diagnosis
P S E	A. _____	Y/N	A. _____
P S E	B. _____	Y/N	B. _____
P S E	C. _____	Y/N	C. _____
P S E	D. _____	Y/N	D. _____
P S E	E. _____	Y/N	E. _____
P S E	F. _____	Y/N	F. _____

P: Punch S: Shave E: Excision

NAME: DOB: PAT ID#: SITE:	A	NAME: DOB: PAT ID#: SITE:	B	NAME: DOB: PAT ID#: SITE:	C
NAME: DOB: PAT ID#: SITE:	D	NAME: DOB: PAT ID#: SITE:	E	NAME: DOB: PAT ID#: SITE:	F

Using this requisition will guarantee your specimens will go to the University of Florida Department of Dermatology and are read by dermatopathologists in the Department.

Phone: (352) 594-1935 • Toll-Free: (855) 483-7546 • Fax: (352) 594-1504 • www.dermatology.med.ufl.edu/dermpath

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4037 NW 86th Terrace, Gainesville, FL 32606



**Physician/Client Information**

Exquisite Dermatology  
12315 Lake Underhill Rd  
Orlando, FL 32828  
P: 407-403-5620, F: 407-412-5920

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**Ordering Physician:**

Sarah Vauiso, ARNP

ICD-9 ICD-9 ICD-9 ICD-9

Collection Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Special Requests:

Patient History/Special Requests:

\_\_\_\_\_

	Biopsy Site	Margins	Clinical Diagnosis
P S E	A. _____	Y/N	A. _____
P S E	B. _____	Y/N	B. _____
P S E	C. _____	Y/N	C. _____
P S E	D. _____	Y/N	D. _____
P S E	E. _____	Y/N	E. _____
P S E	F. _____	Y/N	F. _____

P: Punch S: Shave E: Excision

NAME: DOB: PAT ID#: SITE:	A	NAME: DOB: PAT ID#: SITE:	B	NAME: DOB: PAT ID#: SITE:	C
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