University Hospitals
Cleveland Medical Center

REQUISITION FORM

Dermatology, University Hospitals Medical Group

11100 Euclid Avenue, 3100 Bolwell Health Center
Cleveland, OH 44106-5028

Telephone (216) 844-1507 **Fax: (216) 844-4707**

Dermatopathology **Kord Honda, M.D.**
Immunofluorescence **Neil J. Korman, Ph.D., M.D.**

BIOPSY DATE:

PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE CARD(S)

Hospital Number:

Patient Name: _____
Last First M.I.

Date of Birth/Age: Sex:

Social Security Number:

Street Address:

City/State/Zip:

Home phone: ( ) -

Physician Name:
Physician UPI#

Office Street Address/Site:
City/State/Zip:

Telephone: ( ) - Fax: ( )

Send Copies to (full name): Fax: ( )

Referring Physician Name: Fax: ( )

Insurance Subscriber (Name, Social security #, DOB):

Site of Specimen	Clinical Appearance	Clinical Diagnosis	Biopsy	Excision
A			☐	☐
B			☐	☐
C			☐	☐
D			☐	☐

☐ Routine Histopathology (formalin-fixed tissue)

☐ Direct Immunofluorescence (specimen in Michel's media)

☐ Indirect immunofluorescence (blood in serum-separator tubes)

For Supplies (formalin bottles, transport media): call 216-844-1507

LABORATORY USE ONLY:
Gross Description

Number of specimens:

Specimen size (mm):

Lesion size:

Received in:
- ☐ Formalin
- ☐ Unfixed
- ☐ Transport media
- ☐ Saline

Color:
- ☐ Tan
- ☐ Brown
- ☐ Gray
- ☐ Yellow
- ☐ Red
- ☐ Black

Shape:
- ☐ Ellipsoid
- ☐ Shave
- ☐ Cylindrical
- ☐ Ovoid
- ☐ Irregularly shaped
- ☐ Cyst
- ☐ Dome-shaped

Embedded:
- ☐ Inked
- ☐ In part
- ☐ In toto