Keck Medical Center of USC

USC Care Medical Group, Inc.
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DERMATOPATHOLOGY REQUISITION

(Please type or print clearly. Complete all fields)

LAB ONLY
DP/DC/IF_____
A-
B-
C-
D-

PHYSICIAN: Dr. Zoe Indigo – Skintervention Dermatology DATE OF BIOPSY:_____
343 N. Canon Drive, Beverly Hills, CA 90210, Tel: (424) 313-4794, Fax: (917) 900-1526

PATIENT NAME:_____
LAST FIRST MI

DATE OF BIRTH: _____ MRN:_____ SEX: M / F

PATIENT ADDRESS:_____

BILLING: ☐ Insurance/ Medicare ☐ Physician ☐ Patient ☐ Other _____

INSURANCE/MEDICARE NUMBER:_____
(Include a copy of the insurance card [front & back])

SPECIMEN A:

Site:	Clinical history and findings:
□ Shave □ DIF □ Punch □ Alopecia □ Curette □ Mohs consult □ Nail □ Slide consult □ Excision □ _____	DDX:

SPECIMEN B:

Site:	Clinical history and findings:
□ Shave □ DIF □ Punch □ Alopecia □ Curette □ Mohs consult □ Nail □ Slide consult □ Excision □ _____	DDX:

SPECIMEN C:

Site:	Clinical history and findings:
□ Shave □ DIF □ Punch □ Alopecia □ Curette □ Mohs consult □ Nail □ Slide consult □ Excision □ _____	DDX:

SPECIMEN D:

Site:	Clinical history and findings:
□ Shave □ DIF □ Punch □ Alopecia □ Curette □ Mohs consult □ Nail □ Slide consult □ Excision □ _____	DDX: