Dermatology
Brown Health Medical Group
BROWNHealth
UNIVERSITY

Dermatopathology Form

Leslie Robinson-Bostom, M.D.
Division Director

Christopher DiMarco, M.D.

Brown Health Medical Group
Dermatology Dermatopathology
167 Point St, Suite 260
Providence, RI 02903

Phone (401) 444-8511
Fax (401) 632-0340

Specimen Number _____

Date Received _____

FOR LAB USE ONLY

LAST NAME	FIRST NAME	BIRTH DATE	BIOPSY DATE
ADDRESS	HOME TELEPHONE		SEX
CITY	STATE		ZIP CODE
PRIMARY INSURANCE TYPE			
CLAIMS ADDRESS			
SUBSCRIBER'S NAME		DOB	
ID #		GROUP #	
SECONDARY INSURANCE (POLICYHOLDER NAME, PLAN NAME, ADDRESS, POLICY #)		GROUP #	
CLINICAL DESCRIPTION OF LESION(S)			

ANATOMICAL SITE	PREOP/POSTOP DIAGNOSIS	CHECK ALL THAT APPLY
A)		☐ Shave ☐ Alopecia ☐ Margins ☐ Punch ☐ Nail ☐ Excision/Incision ☐ Panniculitis
B)		☐ Shave ☐ Alopecia ☐ Margins ☐ Punch ☐ Nail ☐ Excision/Incision ☐ Panniculitis
C)		☐ Shave ☐ Alopecia ☐ Margins ☐ Punch ☐ Nail ☐ Excision/Incision ☐ Panniculitis
SUBMITTING PHYSICIAN		PHONE #

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PATHOLOGIC DIAGNOSIS A)	B)	C)

H&E	SPECIAL STAINS	CONSULTS	IMMUNOS	DIF	ISH	ICD 10	LRB
88304 _____	88312 _____	88321 _____	88342 _____	88346 _____	88365 _____	A) _____	
88305 _____	88313 _____	88323 _____	88341 _____	88350x4 _____	88364.w _____	B) _____	CD
		88325 _____	88344 _____			C) _____	