



Dermatopathology Consultation Request

UPP-Department of Dermatology

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Office: (412) 864-3860
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*Please complete all fields and attach patient insurance/demographic information. PLEASE PRINT

Physician Name _____ NPI# _____

Address _____

Address _____

City _____ State _____ Country _____ Zip _____

Phone _____ Fax _____ Email _____

Patient Name _____ DOB _____

Clinical History (Include Site):

Special Testing Request (IF/DIF/Flow/Molecular/IHC) _____

Working Diagnosis:

Requesting Physician Signature _____ Date _____

Materials Submitted:

Total Slides: _____

Case Number: _____

Total Blocks: _____

Case Number: _____

Return Materials? Yes No

May Recuts be retained? Yes No