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Abrishami Dermatopathology

Consultation Request Form

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Board Certified Dermatologist
Board Certified Dermatopathologist
California Medical License A86627

Accession #: AC- _____ Date of Biopsy: ____/_____/ 20_____

Patient Name (Last, First): _____ Date of Birth: ____/_____/ _____ Sex: M / F

_____ ☐ Bill Insurance ☐ Bill Doctor ☐ Bill Patient

Requesting Clinician: _____

**If the biopsy represents a portion of a larger lesion, provide the size of the entire lesion also.

A: _____ Bx Size: _____mm Lesion Size: _____mm

Bx Type: ○ Shave ○ Punch ○ Curetting / Nail ○ Mohs Debulk ☐ Check Margins
○ Tangential Excision ○ Primary Excision ○ Exc of Bx-proven:***

Initial Diagnosis:

88321 88312 88342

B: _____ Bx Size: _____mm Lesion Size: _____mm

Bx Type: ○ Shave ○ Punch ○ Curetting / Nail ○ Mohs Debulk ☐ Check Margins
○ Tangential Excision ○ Primary Excision ○ Exc of Bx-proven:***

Initial Diagnosis:

88321 88312 88342

C: _____ Bx Size: _____mm Lesion Size: _____mm

Bx Type: ○ Shave ○ Punch ○ Curetting / Nail ○ Mohs Debulk ☐ Check Margins
○ Tangential Excision ○ Primary Excision ○ Exc of Bx-proven:***

Initial Diagnosis:

88321 88312 88342

D: _____ Bx Size: _____mm Lesion Size: _____mm

Bx Type: ○ Shave ○ Punch ○ Curetting / Nail ○ Mohs Debulk ☐ Check Margins
○ Tangential Excision ○ Primary Excision ○ Exc of Bx-proven:***

Initial Diagnosis:

88321 88312 88342

****Please include important prior biopsy information / accession number, when available.*