



# Delta Dermatology

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**Toll Free:**  
**1-800-530-5088**

## DERMATOPATHOLOGY

PATIENT INFORMATION			
Last Name		First	MI
Address			
City		State	ZIP
Social Security Number			
Medical Record Number		Phone Number	
Date of Birth		___ Male	___ Female
Physician Last Name, First, MI			
Additional Report To:			
Nurse			
Collection Date	Time	Room #	ID #
Clinical History:			

BILLING INFORMATION		
BILL TO: ___ Patient ___ Medicare ___ Medicaid ___ Other		
Subscriber Name	Primary Care Physician	
Medicare Number	Suffix(es)	
Medicaid Number	State	
Policy Number	Group Number	
Primary Insurance Company		
Address		
Secondary Insurance Company	Policy Number	Group number
Address		
<p>MARK AREA FROM WHICH SPECIMEN WAS REMOVED. DESCRIBE SOURCE IN AREA BELOW.</p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <p style="text-align: center;">FRONT BACK</p>		

Site	Impression	Excision To Fat	EDC	Excision	Excision Ck Margins	Biopsy	DIF	FS
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								

<b>LAB USE ONLY</b>   FS DIAGNOSIS:
INITIALS
H&E QC Acceptable _____ Time In _____ Time Out _____ Cryostat temp _____
The results of the Frozen Section examination were reported to the physician listed above on today's date at the time indicated.

No. of Containers Submitted
<b>LAB USE ONLY – ACCESSION NO.</b>