PRINT RESET

# UIDL
## DERMATOPATHOLOGY CONSULT REQUISITION

**University of Iowa Diagnostic Laboratories**
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, IA 52242
**Client Services Toll Free: (866) 844-2522**
Client Services Local: (319) 384-7212
Client Services Fax: (319) 384-7213

**REQUIRED INFORMATION IN RED**

**REFERRING INSTITUTION (CLIENT) INFORMATION**

| | | | | | |
|---|---|---|---|---|---|
| Referring Institution: | | | **UIDL Client:** | | |
| Requisition Completed By: | | Date: | | | |
| Address: | | | | | |
| City: | | State: | | Zip Code: | |
| Phone: | | Fax (Results): | | | |
| Referring Physician: | | Physician's Phone: | | | |

**PATIENT INFORMATION**

| | | | | | |
|---|---|---|---|---|---|
| Last Name: | | First Name: | | | |
| Gender: | ☐ Male ☐ Female | Birth Date: | | | |
| Address: | | | Phone: | | |
| City: | | State: | | Zip Code: | |

**BILLING INFORMATION** — **The UIDL only accepts one billing directive**

The below link details important information to review before selecting a billing option and submitting a specimen to the UIDL for testing.

**https://medicine.uiowa.edu/uidl/sending-case/billing-options**

**Direct Bill**

☐ **Referring Institution (Client)**

☐ **Patient's Insurance**

*Provide complete and valid information or referring institution may be billed*

On date of collection, was your patient:

☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Non-Hospital Inpatient

☐ **Patient (Self-Pay)**

*Only available to Iowa residents without insurance—Prepayment not required.*

**Prepayment Required**

☐ Non-Iowa Resident with non-Iowa Medicaid or no insurance

**CONSULTATION REQUEST**

☐ Dermatopathology ☐ Immunopathology

**SPECIMEN INFORMATION**

| | | | | | |
|---|---|---|---|---|---|
| Collection Date: | | | Collection Time: | | |
| Specimen Type(s): (*Please specify quantity*) | | Slide(s) | | Block(s) | |
| | | Wet tissue | | Frozen tissue | |
| | | Other: | | | |
| Tissue Source/Site: | 1. | | 2. | 3. | |
| 4. | 5. | | 6. | 7. | |
| 8. | 9. | | 10. | 11. | |

**CLINICAL INFORMATION** — **Please include a copy of your report**

| | | | | | | |
|---|---|---|---|---|---|---|
| Diagnosis/ICD-10 Code(s): | 1. | 2. | 3. | 4. | 5. | 6. |

Pertinent Clinical History and Findings:

Clinical Differential Diagnosis: