UIDL
DERMATOPATHOLOGY
CONSULT REQUISITION

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://uidl.medicine.uiowa.edu/billing

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 Patient

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: