DRL Diagnostic Reference Laboratories

UF&Shands
The University Of Florida Health System

COMPLETE FOR ALL PATIENTS ❑ STAT ❑ CALL RESULTS

PATIENT NAME (LAST) (FIRST) (M.I.)			BIRTHDATE / /	SEX M F
STREET ADDRESS CITY	STATE	ZIP CODE	PATIENT PHONE ( ) -	
ORDERING PHYSICIAN	FAX DUPLICATE REPORT TO: ( ) - PHYSICIAN:		BILL TO ❑ CLIENT ❑ INSURANCE	❑ PATIENT ❑ MCARE/MCAID

Please attach copy of Insurance cards (front and back)

PRIMARY INSURANCE NAME	ADDRESS	CITY	STATE	ZIP CODE
IDENTIFICATION / MEMBER #	GROUP #	RESPONSIBLE PARTY / INSURED EMPLOYER		
SECONDARY INSURED NAME	ADDRESS	CITY	STATE	ZIP CODE
IDENTIFICATION / MEMBER #	GROUP #	RESPONSIBLE PARTY / INSURED EMPLOYER		
❑ MEDICARE ID# & LETTER - - -	❑ MEDICAID ID# & LETTER - - -			
RELATIONSHIP TO INSURED: ❑ SELF ❑ SPOUSE ❑ DEPENDENT	POLICY HOLDERS DATE OF BIRTH:			

For any payor, including Medicare and Medicaid, that has a medical necessity requirement, you should only order tests that are medically necessary for the diagnosis and treatment of your patient.

ICD-9	ICD-9	ICD-9	ICD-9	ICD-9	ICD-9

PHYSICIAN

Collection Date: ____________________

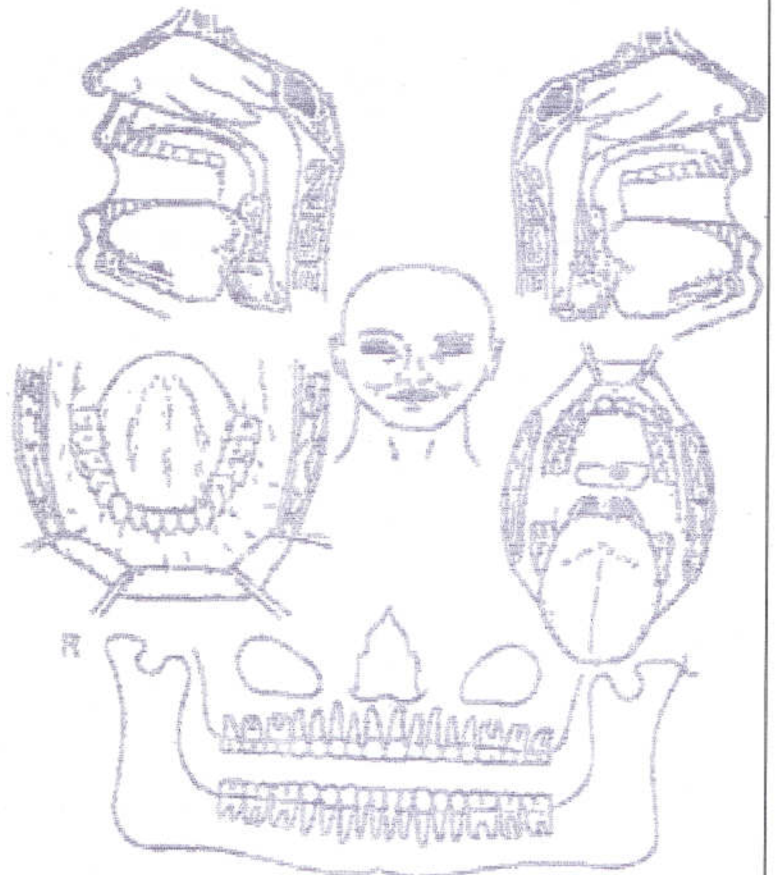
Clinical Information

Exact Location ____________________

Duration ____________ Color __________

Symptoms ____________________

Excisional ___ Incisional ___ Smear ___



Description/History of Lesion:

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Clinical Impression:

____

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UF-206

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