



DATE:				
UFVH MR #:	Send-In Dermatopathology Request Form 2015 SW 16th Ave. Room VS-50 Gainesville, FL 32610			
Owner's Name:	Pamela E. Ginn D.V.M., Dip. A.C.V.P. William F. Craft, Dermatopathology Fellow Phone: 352-294-4726 Fax: 352-392-1769 http://labs.vetmed.ufl.edu dermpath@vetmed.ufl.edu			
Address:				
City/State/Zip:				
Owner's Phone:	<small>For office use only</small> Case #: S _____ - _____ - D			
Patient's Name:	Clinician to contact for more information:			
Species:	Clinician phone Number:			
Breed:	Clinic:			
Sex:	Address:			
Color:	City:			
DOB/Age:	State:	Zip:		
Have photos of these lesions been submitted? <input type="checkbox"/> Via E-mail <input type="checkbox"/> Printed and Attached	Email:		Fax:	
Has tissue from this animal been submitted to UF Anatomic Pathology previously? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is the accession number? ____-____-D		
Container #1				
Container #2				
Container #3				
Check lesions that are present: <input type="checkbox"/> Hyperpigmentation <input type="checkbox"/> Depigmentation <input type="checkbox"/> Erythema <input type="checkbox"/> Papules <input type="checkbox"/> Vesicles <input type="checkbox"/> Scales <input type="checkbox"/> Alopecia <input type="checkbox"/> Pustules <input type="checkbox"/> Plaques <input type="checkbox"/> Nodules <input type="checkbox"/> Crusts <input type="checkbox"/> Lichenification <input type="checkbox"/> Other (specify): _____				
Pruritus: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		Skin Scrape? <input type="checkbox"/> Yes <input type="checkbox"/> No	Bacterial Culture? <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy Testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Seasonal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____		Fungal Culture? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cytology Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
CLINICAL SUMMARY (Include clinical signs, duration of illness, laboratory data, medications, and other pertinent information. Please attach copies of any lab reports.) THIS WILL BE PRINTED VERBATIM ON THE REPORT.				
				
CLINICAL DIAGNOSIS:				
Special Requests: <input type="checkbox"/> Please return a copy of each Slide for an additional cost.				
_____ Signature of Attending Veterinarian			PRINT Last Name	
(UFVH use only) Initials: _____		Ship Code: _____	Invoice Item Code: _____	Total Samples: _____
Condition of Sample: _____ Leaking _____ Damaged _____ Date/Time Stamp:				