

	ST. JOHN'S BIOPSY REQUEST FOR HISTOLOGY			Pathnet Lab. No.	
	Surname:		I.D. No.:		
	Forename:		Hosp/Cons. Room		
St. John's Institute of Dermatology	M/F:		Consultant		
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Please print all information or use a label. Failure to complete correctly and legibly may result in a delay in processing the request, or the return of the sample.					
Biopsy Site					
Biopsy Type (Excision/Incision/Curetting/Punch, etc.)					
Previous Biopsy		YES/NO	Previous La	rious Lab. No. (if known)	
IMF Investigations		YES/NO	IMF Lab. No	No. (if known)	
Clinical Info/Relevant History:					
Suggested clinical diagnosis:					
Billing info/special ins		tructions:	Date:		
			Signatur	e:	
St. John's Institute of Dermatology, Block 7, South Wing, 2 nd Floor, St. Thomas' Hospital. Lab. Tel. 020 7188 6408 Fax 020 7188 6382 – Laboratory Manager: Guy Orchard, Tel. 020 7188 8160					

Filename: DMH-LF-175 Dermatopathology Request Form

Authorised by: G Orchard Page 1

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