

HCT DERMATOPATHOLOGY SERVICES

900 South Caton Avenue • Baltimore, MD 21229

Tel 1-888-413-8860 • Fax (410) 368-8996

PATIENT INFORMATION			
LAST NAME	FIRST NAME	M.I.	
STREET ADDRESS			APT. #
CITY	STATE	ZIP CODE	
PHONE NUMBER	SOCIAL SECURITY NUMBER		
DATE OF BIRTH	SEX	AGE	

PHYSICIAN INFORMATION

ALOPECIA CONSULTATION CASE FOR DR. LEONARD SPERLING

Please note: An insurance claim will not be processed by HCT
(the submitting institution or physician will be invoiced).

SITE	CHECK	CLINICAL DIAGNOSIS AND HISTORY	ICD-9 CODES
A	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
B	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
C	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
D	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
E	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
F	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
G	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
H	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
I	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
J	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
K	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
L	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
M	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
N	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
O	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
P	<input type="checkbox"/> SHAVE <input type="checkbox"/> PUNCH <input type="checkbox"/> EXCISION		
PHYSICIAN'S SIGNATURE: X		DATE COLLECTED:	<input type="checkbox"/> RUSH

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Alopecia Worksheet

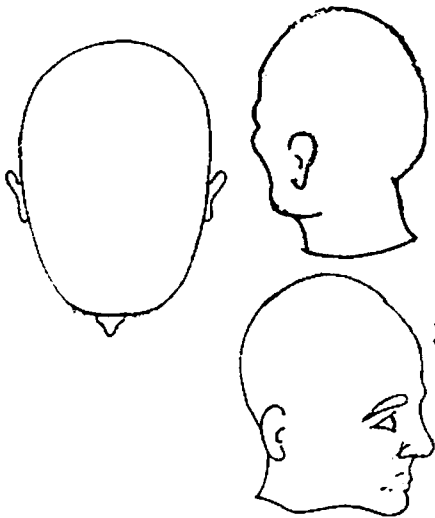
(Please attach to standard HCT requisition form)

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Patient Name:

Biopsy site (location on scalp)	Type of Biopsy	Size of Biopsy	ICD-9
A.	Punch Excision	<input type="checkbox"/> 2 mm punch <input type="checkbox"/> 3 mm punch <input type="checkbox"/> 4 mm punch (PREFERRED)	
B.	Punch Excision	<input type="checkbox"/> 2 mm punch <input type="checkbox"/> 3 mm punch <input type="checkbox"/> 4 mm punch (PREFERRED)	
Race of Patient:		If multiple biopsies: <ul style="list-style-type: none"> • Please place in separate containers, indicating specific site on scalp • Please indicate if sites on scalp appear clinically similar or different 	

Clinical Pattern of Hair loss (please describe, then show area(s) of involvement and biopsy sites on diagram):



Clinical photos included (digital photos may be e-mailed to alopecia@hctpath.com : please include patient initials with photos for identification)

Clinical Differential Diagnosis: