



Yale Dermatopathology  
Rossitza Lazova, MD

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## Request for Specimen

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Pathology Laboratory: \_\_\_\_\_

Please submit reports, blocks, and slides for case #: \_\_\_\_\_

To YALE DERMATOPATHOLOGY LABORATORY for use in the Spitzoid

Neoplasm Repository.

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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