1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE/SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

VISIT TYPE: DERMATOPATHOLOGY CONSULTATION / PATHOLOGY REVIEW / SLIDE REVIEW / BIOPSY CORRELATION / CASE CONFERENCE / FOLLOW-UP

CARE SETTING: DERMATOPATHOLOGY LAB / DERMATOLOGY CLINIC / ACADEMIC CLINIC / MULTIDISCIPLINARY CONFERENCE / TELEHEALTH

REFERRING DERMATOLOGIST / CLINICIAN

PRIMARY CARE PROVIDER, IF APPLICABLE

SPECIMEN ACCESSION NUMBER

SPECIMEN DATE

REPORT DATE

INTERPRETER USED, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY DIAGNOSTIC QUESTION

Document the primary dermatopathology-related reason for the visit or review, including skin biopsy interpretation, clinicopathologic correlation, second-opinion pathology review, atypical lesion evaluation, inflammatory dermatosis workup, suspected malignancy, margin assessment, immunofluorescence review, molecular testing review, excision pathology review, or discordant clinical-pathologic findings.

S SUBJECTIVE

3 CLINICAL HISTORY SUPPLIED

Document the clinical history supplied by the referring clinician, patient-reported history when available, lesion behavior, prior

pathology, treatment history, and diagnostic question.

3a DIAGNOSTIC QUESTION & SPECIMEN

Reason for Dermatopathology Review:

Document whether the review is for primary biopsy interpretation, slide consultation, clinicopathologic correlation, malignancy classification, inflammatory dermatosis diagnosis, alopecia evaluation, blistering disease evaluation, vasculitis evaluation, infection evaluation, margin status, recurrent lesion assessment, or second opinion.

Clinical Question:

Document the specific diagnostic concern, including melanoma versus nevus, basal cell carcinoma subtype, squamous cell carcinoma features, cutaneous lymphoma, drug eruption, psoriasis versus eczema, lupus, vasculitis, bullous disease, alopecia subtype, infection, or other differential diagnosis.

Lesion / Rash Clinical History:

Document location, duration, size, color, morphology, distribution, symptoms, growth/change, bleeding, ulceration, itching, pain, recurrence, prior trauma, and relationship to clinical photographs when provided.

Specimen Site and Procedure Type:

Document anatomic site, laterality, biopsy type, excision type, punch size if known, shave biopsy, saucerization, excision, curettage specimen, Mohs debulk specimen, nail unit specimen, scalp biopsy, mucosal biopsy, or direct immunofluorescence specimen.

3b BACKGROUND & PRIOR PATHOLOGY

Prior Dermatologic History:

Include prior melanoma, non-melanoma skin cancer, dysplastic nevi, atypical lesions, inflammatory dermatoses, autoimmune skin disease, blistering disease, alopecia, cutaneous lymphoma, chronic ulcers, infections, or prior dermatopathology results.

Treatment History:

Document topical therapies, systemic therapies, biologics, immunosuppressants, antibiotics, antifungals, antivirals, phototherapy, prior surgery, radiation, chemotherapy, immunotherapy, field therapy, or treatment before biopsy that may alter histology.

Medication and Exposure History:

Document recent new medications, immune checkpoint inhibitors, biologics, immunosuppressants, anticoagulants, antibiotics, antiepileptics, supplements, occupational exposures, travel, infections, animal exposures, and possible drug or contact triggers.

Relevant Medical History:

Include immunosuppression, transplant history, HIV, autoimmune disease, connective tissue disease, inflammatory bowel disease, hematologic malignancy, cancer history, radiation exposure, chronic infection, or systemic symptoms relevant to the pathology.

Family History:

Document family history of melanoma, genetic cancer syndromes, autoimmune disease, psoriasis, blistering disease, alopecia, or inherited skin disorders when relevant.

Clinical Images / Dermoscopy, if available:

Document whether photographs, dermoscopy images, body map, prior measurements, lesion comparison, or clinical diagrams were reviewed.

Prior Pathology / Outside Slides:

Document prior accession numbers, diagnoses, margin status, immunostains, molecular results, outside institution, and whether slides/blocks were available for review.

Pertinent Negatives:

Document absence of clinically relevant features when supplied, including no rapid growth, no ulceration, no bleeding, no systemic symptoms, no immunosuppression, no prior skin cancer, no medication trigger, or no mucosal involvement, when relevant to diagnostic interpretation.

ROS DERMATOPATHOLOGY REVIEW OF SYSTEMS

4 CLINICALLY RELEVANT INFORMATION

Document only clinically relevant review-of-systems information available from the referral, chart, or patient encounter when applicable:

Skin lesion change, bleeding, ulceration, pain, itching, or recurrence

Rash distribution, photosensitivity, mucosal involvement, blistering, or systemic symptoms

Fever, weight loss, night sweats, lymphadenopathy, fatigue, or constitutional symptoms

Joint pain, oral ulcers, Raynaud symptoms, sicca symptoms, muscle weakness, or autoimmune symptoms

Hair loss, scalp symptoms, nail changes, or mucosal lesions

Medication reaction symptoms, new drug exposure, infection exposure, or immunosuppression-related concerns

Treatment response or progression despite therapy

O OBJECTIVE

5 SPECIMEN & MICROSCOPIC FINDINGS

Document pathology-relevant objective data, specimen details, microscopic findings, and clinicopathologic correlation.

5a SPECIMEN INFORMATION

ACCESSION NUMBER

SPECIMEN SITE

LATERALITY

SPECIMEN TYPE: SHAVE / PUNCH / EXCISION / CURETTAGE / INCISIONAL BIOPSY / NAIL UNIT / SCALP BIOPSY / MUCOSAL BIOPSY / DIF SPECIMEN / OTHER

NUMBER OF SPECIMENS

CLINICAL DIAGNOSIS / DIFFERENTIAL

GROSS DESCRIPTION AVAILABLE

CLINICAL IMAGES REVIEWED: YES / NO

OUTSIDE SLIDES REVIEWED: YES / NO

5b GROSS & MICROSCOPIC FINDINGS

Gross Description:

Document specimen dimensions, tissue type, skin ellipse or fragment details, lesion size if grossly visible, orientation markers, inked margins, sectioning, cassette submission, and limitations such as fragmented, transected, superficial, or scant specimen.

Microscopic Description:

Document epidermal, dermal, subcutaneous, adnexal, vascular, inflammatory, melanocytic, keratinocytic, infectious, fibrosing, granulomatous, interface, spongiotic, psoriasiform, lichenoid, vasculitic, bullous, panniculitic, or neoplastic findings.

Epidermal Findings:

Document hyperkeratosis, parakeratosis, acanthosis, atrophy, spongiosis, interface change, dyskeratosis, ulceration, crust, vesiculation, acantholysis, atypia, pagetoid spread, or epidermal necrosis.

Dermal Findings:

Document inflammatory pattern, infiltrate type and density, fibrosis, mucin, granulomas, vasculitis, eosinophils, plasma cells, neutrophils, lymphocytes, histiocytes, adnexal involvement, solar elastosis, hemorrhage, edema, or tumor invasion.

Subcutaneous Findings, if present:

Document septal or lobular panniculitis, vasculitis, fat necrosis, granulomas, organisms, atypical infiltrate, depth of tumor, or specimen limitations.

Melanocytic Findings, if applicable:

Document architecture, symmetry, circumscription, nesting pattern, pagetoid spread, cytologic atypia, maturation, mitotic activity, regression, ulceration, lymphovascular invasion, perineural invasion, Breslow depth, Clark level if used, margins, and melanoma staging elements when relevant.

Keratinocytic Tumor Findings, if applicable:

Document basal cell carcinoma subtype, squamous cell carcinoma differentiation, depth of invasion, perineural invasion, lymphovascular invasion, acantholysis, desmoplasia, aggressive features, actinic damage, and margin involvement.

Inflammatory Dermatosis Pattern:

Document pattern-based findings such as spongiotic dermatitis, psoriasiform dermatitis, interface dermatitis, lichenoid dermatitis, granulomatous dermatitis, vasculitis, panniculitis, urticarial dermatitis, neutrophilic dermatosis, folliculitis, or alopecia pattern.

Infectious Findings:

Document organisms seen or suspected, fungal hyphae/yeast, bacteria, viral cytopathic effect, parasites, granulomatous response, suppuration, special stain results, and culture correlation when available.

Hair / Scalp Biopsy Findings, if applicable:

Document follicular density, terminal:vellus ratio, anagen/telogen ratio when assessed, miniaturization, scarring, perifollicular inflammation, follicular dropout, sebaceous gland status, interface change, fungal elements, and horizontal/vertical section interpretation.

Nail Unit Findings, if applicable:

Document nail plate, nail bed, matrix, fungal elements, melanocytic lesion features, inflammation, tumor involvement, and margin status.

AS ANCILLARY STUDIES

6 STAINS, IHC, DIF & MOLECULAR

Document special stains, immunohistochemistry, immunofluorescence, molecular testing, and ancillary interpretation. Include:

Special Stains:

PAS, GMS, Gram, AFB, Fite, Warthin-Starry, mucin stains, iron stain, elastic stain, or other stains used and results.

Immunohistochemistry:

Marker panel, staining pattern, positive/negative controls, diagnostic interpretation, and limitations.

Melanocytic Markers:

SOX10, Melan-A/MART-1, HMB-45, PRAME, Ki-67, p16, BAP1, or other markers when used.

Epithelial / Carcinoma Markers:

BerEP4, EMA, CK5/6, p63, p40, cytokeratins, CEA, or other markers when used.

Lymphoid Markers:

CD3, CD4, CD8, CD20, CD30, CD56, TCR markers, Ki-67, clonality studies, or flow/molecular correlation when applicable.

Direct Immunofluorescence:

IgG, IgA, IgM, C3, fibrinogen patterns, basement membrane zone deposition, intercellular deposition, vessel wall deposition, and diagnostic interpretation.

Molecular / Genetic Testing:

FISH, PCR, gene rearrangement, next-generation sequencing, BRAF, NRAS, KIT, TERT, HRAS, or other molecular testing and clinical relevance.

Margin Assessment:

Peripheral and deep margin status, involved margin location, transection, close margins, and limitations due to specimen orientation or fragmentation.

CPC CLINICOPATHOLOGIC CORRELATION

7 CLINICAL–PATHOLOGIC CONCORDANCE

Document correlation between clinical findings and pathology. Include:

WHETHER HISTOLOGY SUPPORTS THE CLINICAL DIAGNOSIS

WHETHER FINDINGS ARE DIAGNOSTIC, COMPATIBLE, NONSPECIFIC, OR DISCORDANT

KEY FEATURES SUPPORTING THE DIAGNOSIS

IMPORTANT DIFFERENTIAL DIAGNOSES

LIMITATIONS OF SPECIMEN DEPTH, SAMPLING, SITE, PRIOR TREATMENT, OR ARTIFACT

NEED FOR REPEAT BIOPSY, DEEPER BIOPSY, EXCISION, CULTURE, DIF, ADDITIONAL STAINS, MOLECULAR TESTING, OR CLINICAL FOLLOW-UP

COMMUNICATION WITH REFERRING CLINICIAN WHEN CLINICALLY IMPORTANT

DI DIAGNOSTIC IMPRESSION

8 FINAL DERMATOPATHOLOGY INTERPRETATION

Document final dermatopathology interpretation. Include:

FINAL DIAGNOSIS FOR EACH SPECIMEN

DIAGNOSIS CERTAINTY: DIAGNOSTIC / CONSISTENT WITH / SUGGESTIVE OF / COMPATIBLE WITH / NONSPECIFIC

TUMOR TYPE, SUBTYPE, GRADE, DEPTH, MARGINS, AND STAGING ELEMENTS WHEN APPLICABLE

INFLAMMATORY PATTERN AND DIFFERENTIAL DIAGNOSIS WHEN APPLICABLE

INFECTIOUS ORGANISMS OR NEED FOR MICROBIOLOGIC CORRELATION

DIRECT IMMUNOFLUORESCENCE INTERPRETATION WHEN APPLICABLE

ANCILLARY STUDY INTERPRETATION

COMMENT WITH CLINICAL RELEVANCE AND RECOMMENDED CORRELATION

L LABORATORY AND DIAGNOSTIC RESULTS REVIEWED

9 RESULTS INCORPORATED

Document dermatopathology-relevant results reviewed or incorporated. Include:

PRIOR BIOPSY OR EXCISION REPORTS

OUTSIDE SLIDE REVIEW

CLINICAL PHOTOGRAPHS OR DERMOSCOPY IMAGES

MICROBIOLOGY CULTURES OR PCR RESULTS

SEROLOGIC TESTS, AUTOIMMUNE LABS, OR INFLAMMATORY MARKERS

IMAGING FOR TUMOR STAGING, LYMPH NODE CONCERN, OR DEEP EXTENSION

MEDICATION MONITORING LABS WHEN RELEVANT

PRIOR DERMATOLOGY, ONCOLOGY, RHEUMATOLOGY, INFECTIOUS DISEASE, OR PRIMARY CARE RECORDS

OPERATIVE REPORTS, MOHS MAPS, EXCISION DIAGRAMS, AND MARGIN DOCUMENTATION

A ASSESSMENT

10 DERMATOPATHOLOGIC INTERPRETATION

Provide dermatopathology-specific clinical interpretation: Primary dermatopathologic diagnosis or diagnostic category · Key microscopic findings supporting the diagnosis · Differential diagnoses considered and excluded when applicable · Clinicopathologic concordance or discordance · Margin status and adequacy of sampling · Tumor risk features, including depth, invasion, differentiation, ulceration, mitotic rate, perineural invasion, lymphovascular invasion, or aggressive subtype when relevant · Ancillary study significance and limitations · Need for additional sections, stains, molecular testing, outside consultation, repeat biopsy, excision, Mohs surgery, oncology referral, or clinical follow-up · Urgent or unexpected findings requiring direct communication.

P PLAN

11 RECOMMENDATIONS & COMMUNICATION

Outline dermatopathology recommendations and communication plan. Include:

Final pathology report completion and diagnostic wording.

Recommendation for clinicopathologic correlation when findings are nonspecific or discordant.

Recommendation for re-biopsy, deeper biopsy, excision, Mohs surgery, margin re-excision, or additional sampling when indicated.

Recommendation for additional stains, immunohistochemistry, direct immunofluorescence, molecular testing, or outside expert consultation when needed.

Recommendation for microbiologic culture, serologic testing, imaging, or systemic evaluation when histology suggests infection, autoimmune disease, lymphoma, vasculitis, panniculitis, or metastatic disease.

Recommendation for dermatology, Mohs surgery, oncology, rheumatology, infectious disease, hematology/oncology, genetics, or primary care coordination when indicated.

Documentation of direct communication with referring clinician for malignant, unexpected, urgent, discordant, or clinically significant findings.

Patient-facing explanation plan if results are discussed during a clinical visit, including diagnosis, uncertainty, next steps, and expected follow-up.

Pathology addendum plan for pending stains, deeper levels, outside slides, molecular testing, or amended diagnosis if needed.

F FOLLOW-UP

12 PENDING ITEMS & REVIEW

Specify follow-up timeframe and purpose, including final report addendum, pending stain review, deeper level review, outside slide comparison, molecular testing result review, clinicopathologic conference, repeat biopsy correlation, excision/Mohs pathology review, or communication with referring clinician.

TB TIME DOCUMENTATION & BILLING

13 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT

MICROSCOPIC REVIEW TIME

CLINICAL CORRELATION TIME

ANCILLARY STUDY REVIEW TIME

OUTSIDE SLIDE REVIEW TIME, IF APPLICABLE

CARE COORDINATION / CLINICIAN COMMUNICATION TIME

REPORT ADDENDUM TIME, IF APPLICABLE

13a BILLING CONSIDERATIONS — DERMATOPATHOLOGY CODING

SURGICAL PATHOLOGY CODE(S)

CONSULTATION / OUTSIDE SLIDE REVIEW CODE(S), IF APPLICABLE

SPECIAL STAIN CODE(S), IF APPLICABLE

IMMUNOHISTOCHEMISTRY CODE(S), IF APPLICABLE

DIRECT IMMUNOFLUORESCENCE CODE(S), IF APPLICABLE

MOLECULAR TESTING CODE(S), IF APPLICABLE

ADDENDUM / ANCILLARY REVIEW DOCUMENTATION, IF APPLICABLE

BASIS FOR BILLING: [SPECIMEN INTERPRETATION / CONSULTATION / ANCILLARY STAINS / IMMUNOFLUORESCENCE / MOLECULAR TESTING / CLINICOPATHOLOGIC CORRELATION]

ICD-10 DIAGNOSIS CODES: [PRIMARY DERMATOPATHOLOGY DIAGNOSIS CODE + DESCRIPTION]

[SECONDARY LESION / MALIGNANCY / INFLAMMATORY / INFECTIOUS DIAGNOSIS CODE(S), IF APPLICABLE]

SO SIGNATURE

14 PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: DERMATOPATHOLOGY

DATE

TIME

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