

PATHC/ Pathology Consultation

Client Information *(required)*

Client Name		
Client Account No.		
Client Phone	Client Order No.	
Street Address		
City	State	ZIP Code

Patient Information *(required)*

Patient ID (Medical Record No.)		
Patient Name <i>(Last, First, Middle)</i>		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date <i>(mm-dd-yyyy)</i>	
Collection Date <i>(mm-dd-yyyy)</i>	Time	<input type="checkbox"/> am <input type="checkbox"/> pm

Submitting Provider Information *(required)*

Submitting/Referring Provider Name <i>(Last, First)</i>

Fill in only if Call Back is required.

Phone (with area code)	Fax (with area code)
Provider's National I.D. (NPI)	

**Fax number given must be from a fax machine that complies with applicable HIPAA regulation.*

Note: It is the client's responsibility to maintain documentation of the order.

New York State Patients: Informed Consent for Genetic Testing

"I hereby confirm that informed consent has been signed by an individual legally authorized to do so and is on file with this office or the individual's provider's office."

Signature ▶

Note: Test requests without a signature will not be performed.

Ship specimens to:

Mayo Clinic Laboratories
3050 Superior Drive NW
Rochester, MN 55901

Customer Service: 855-516-8404

Visit www.MayoClinicLabs.com for the most up-to-date test and shipping information.

Pathology Case Information

A preliminary/final pathology report is required for each case submitted.

Pathology Case Number	
You may direct your case to a specific subspecialty or individual pathologist.	
<input type="checkbox"/> Bone and Soft Tissue**	<input type="checkbox"/> Infectious Diseases
<input type="checkbox"/> Breast	<input type="checkbox"/> Neuropathology**
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Ophthalmic
<input type="checkbox"/> Cytology (FNA)	<input type="checkbox"/> Placenta
<input type="checkbox"/> Dermatopathology	<input type="checkbox"/> Pulmonary (Thoracic)**
<input type="checkbox"/> Endocrine	<input type="checkbox"/> Renal
<input type="checkbox"/> Gastrointestinal/Liver	<input type="checkbox"/> Urologic
<input type="checkbox"/> Gynecologic	<input type="checkbox"/> Unknown/Multiple
<input type="checkbox"/> Head and Neck**	To direct case to a specific pathologist, write name:
<input type="checkbox"/> Hematopathology	

****Submit imaging and/or clinical photos if appropriate.**

Reason for Consultation *(required)*

<i>e.g., tumor classification, margin status</i>
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Clinical Notes *(recommended)*

<i>e.g., patient history, lab values</i>
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MCL Internal Use Only

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Billing Information

- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing related questions:

800-447-6424 (US and Canada)
507-266-5490 (outside the US)