

Pathology Consultation Request

PATHC / Pathology Consultation

| Client Information (required) | | | Pathology Case Information (required) | | | |
|---|-----------------------|------------------------|---|---------------------------------------|---|--------------------|
| Client Name | | | A preliminary/final pathology report is required for each case submitted. Client Pathology Case Number | | | |
| | | | | | | Client Account No. |
| Client Phone Client Order No. | | ☐ Bone and soft tissue | e 🗆 Infection | ☐ Infectious Diseases | | |
| Client Phone | Client Ord | der No. | ☐ Breast | | ☐ Neuropathology | |
| Street Address | | | ☐ Cardiovascular | · · · · · · · · · · · · · · · · · · · | ☐ Opthalmic | |
| Street Address | | | ☐ Cytology (FNA) | | ☐ Placenta | |
| City | State | ZIP Code | ☐ Dermatopathology | | ☐ Pulmonary (Thoracic) | |
| City | State | Zii Code | ☐ Endocrine | | ☐ Medical Renal | |
| | | | Gastrointestinal/Liv | O | ☐ Urologic☐ Unknown/Multiple | |
| Patient Information (required) | | | | | | |
| Patient ID (Medical Record No.) | | | ☐ Hematopathology | | case to a specific st, enter name: | |
| | | | | patriologic | ot, circoi riarrio. | |
| Patient Name (Last, First Middle) | | | Include corresponding imaging (bone tumors, neurology tumors, medical lung) and laboratory data (medical liver and medical kidney) with submission. | | | |
| Sex | Birth Date | e (mm-dd-yyyy) | Tissue Specimens Provided (required) | | | |
| ☐ Male ☐ Female | | | | | | |
| Collection Date (mm-dd-yyyy) | Time | □ am □ pm | Procedure (eg, biopsy, resection): | Tissue source: | List block numbers: | |
| Submitting Healthcare Prof | fessional Ir | nformation (required |) | | | |
| Submitting/Referring Healthcare Professional Name (Last, First) | | |] | | Number of slides sent: | |
| Fill in only if Call Back is required. | | | Reason for Consultation (required) | | | |
| Phone (with area code) | Fax* (with area code) | | eg, tumor classification, margin status | | | |
| National Provider Identification (N | PI) | | - | | | |
| *Fax number given must be from a fax mach HIPAA regulation. | ine that complie: | s with applicable | | | | |
| MCL Internal Use Only | | | Clinical Notes (reco | ommended) | | |
| | | | eg, patient history, lab values | | | |
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| - | | | | | | |
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Ship specimens to:

Mayo Clinic Laboratories 3050 Superior Drive NW Rochester, MN 55905

Customer Service: 800-533-1710

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

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)