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**SURGICAL PATHOLOGY/CYTOLOGY
 CONSULTATION REQUEST**

INFORMATION IN BLUE IS REQUIRED.

CPA- [REDACTED]

Billing Information (Check box(es) & provide billing information below or attach insurance card) Bill To: <input type="checkbox"/> Primary Insurance <input type="checkbox"/> Patient (Self Pay) <input type="checkbox"/> Other (Indicate below) <input type="checkbox"/> Secondary Insurance <input type="checkbox"/> Doctor /Group		Patient Name (Last, First, MI)	
Insurance Company		Address	
Insurance Company Address		Social Security #	
Policy No.		Group No.	
Policyholder's Name		D.O.B.	
Policyholder's Address		Sex	
Place of Employment		Date of Service	
Insurance Company		Physician's Signature	
Insurance Company Address		Print Physician Name	
Policy No.		Group No.	
Policyholder's Name		Name & Phone #	
Policyholder's Address		S.P. Accession No.	
Place of Employment		LOCATION <input type="checkbox"/> Private Office <input type="checkbox"/> MJ- OSC <input type="checkbox"/> Other _____	
Previous Pathology Accession #'s		Intraoperative Consult <input type="checkbox"/> Yes <input type="checkbox"/> No	
Specimen Type <input type="checkbox"/> Biopsy <input type="checkbox"/> Excision <input type="checkbox"/> Other: _____		Collection Time:	
Clinical History: (REQUIRED INFO.)		Time in Formalin:	
ICD9 Codes		Diagram/Orientation/Special Instructions:	
LMP:			
Diagnosis:			

SPECIMEN SOURCE (REQUIRED INFO.)

①	⑦
②	⑧
③	⑨
④	⑩
⑤	⑪
⑥	⑫

FOR PATHOLOGY USE ONLY

NAME _____	NAME _____	NAME _____	NAME _____
DOB _____	DOB _____	DOB _____	DOB _____
SOURCE _____	SOURCE _____	SOURCE _____	SOURCE _____
NAME _____	NAME _____	NAME _____	NAME _____
DOB _____	DOB _____	DOB _____	DOB _____
SOURCE _____	SOURCE _____	SOURCE _____	SOURCE _____