

**Martha  
Jefferson Hospital**

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 Department of Pathology  
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**SURGICAL PATHOLOGY / CYTOLOGY  
 CONSULTATION REQUEST**

**INFORMATION IN RED IS REQUIRED.**

<b>P R I M A R Y</b>	Insurance Company		Patient Name (Last, First, MI)		
	Insurance Company Address		Address		
	Policy No.	Group No.			
	Policyholder's Name		Social Security #	Phone #	
	Policyholder's Address		Doctor		
	Place of Employment		D.O.B.	Sex	Date of Service
<b>S E C O N D A R Y</b>	Insurance Company		MR No.	Account No.	
	Insurance Company Address		Physician's Signature		
	Policy No.	Group No.	<b>LOCATION</b> <input type="checkbox"/> Inpatient Surgery <input type="checkbox"/> Outpatient Surgery <input type="checkbox"/> Endoscopy <input type="checkbox"/> Room No. _____ <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Medical Imaging <input type="checkbox"/> Other _____ <b>Intraoperative Consult</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> OR Room No. _____		
	Policyholder's Name				
	Policyholder's Address				
	Place of Employment				
Previous Pathology Accession Numbers		<b>CC of Report To</b>  Name & Phone #  S.P. Accession No.			
Specimen Type <input type="checkbox"/> Biopsy <input type="checkbox"/> Excision <input type="checkbox"/> Other: _____					
<b>Clinical History:</b> (REQUIRED INFO.) _____ _____ _____  LMP: _____		Collection Time: _____		Time in Formalin: _____	
Diagnosis:		Diagram/Orientation/Special Instructions:			
<b>SPECIMEN SOURCE (REQUIRED INFO.)</b>					
①				⑦	
②				⑧	
③				⑨	
④				⑩	
⑤				⑪	
⑥				⑫	
<b>FOR PATHOLOGY USE ONLY</b>					

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