

MEDICAL DIRECTOR: WAYNE M. SCHULTHEIS, M.D.

REFERRED BY

/
/

DATE COLLECTED

PATIENT INFORMATION

LAST NAME ▲	FIRST NAME	INITIAL
ADDRESS ▲		
CITY ▲	STATE ▲	ZIP REQUIRED ▲
AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTH DATE
	AREA CODE	PHONE

- BILL INSURANCE BILL PATIENT
 UNINSURED / CASH PAY

History / Differential Dx (required):

ICD-10 Codes:

MEDICAL RECORD # _____

RESPONSIBLE PARTY	(Please send photocopy of insurance card, both sides.)	
INSURANCE CO. NAME		GROUP NO.
INSURANCE CO. ADDRESS		POLICY NO.

Copies to additional physician (print full name): _____

Contact Phone # for Frozen Section: _____

PATHOLOGY SPECIMENS Indicate site, fixative. Submit specimen fresh for frozen section.

Submitted: fresh formalin (10% or zinc) at _____ o'clock fresh for frozen section

#	Site	Section	Cassette
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			

BREAST TABLE

Required for all breast samples fill out Breast Table

Specimen number	Time taken out of patient	Time placed in 10% formalin

For Pathology Use Only

Consultation SCHEDULED UNSCHEDULED
at Surgery GROSS FROZEN

CYTOLOGY SPECIMENS (non-gyn cytology & fine needle aspirations):

Indicate site, fixative, and any other features

Submitted in: alcohol no fixative other _____

		Slides	Fluid

FOR LAB USE ONLY:

VP-01