ANATOMIC PATHOLOGY CONSULTATION REQUEST

Medical University of South Carolina
Pathology and Laboratory Services
165 Ashley Avenue, Room EH318
Charleston, SC 29425
Phone (843) 792-3821
Fax (843) 792-8974

Ordering Location: ______________________________

Phone #: ______________________________

Form Origination Date: 1/00
Version: 3
Version Date: 12/15

PATIENT IDENTIFICATION LABEL

1. Complete Patient Demographic Information if patient identification or IDX label is not available

Patient Name (Last, First, MI)			**THIS AREA FOR LAB USE**
DOB	Sex	Race	Accession Number: ______________
MRN#	PATCOM#		Received Date / Time: ______________

2. Complete General Specimen Information

Ordering Provider Full Name (Please print)

______________________ Pager ID _____

Ordering Provider Signature

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Collection Date: ______________

Collection Time: ______________

Number of Specimens ______________
Number of Blocks ______________
Number of Slides ______________

Routing Information

- ☐ Surgical
- ☐ Skin
- ☐ Neuropathology
- ☐ Immunopathology
- ☐ Slide Consult

- ☐ Frozen Section
- ☐ Tumor Bank: Specify______________
  Ext. 2-8165 / Pager 17291
- ☐ Routine
- ☐ Rush (24 Hour)
- ☐ Special Procedure
  specify: ______________

3. Complete Information Required for Proper Evaluation

Diagnosis(es) or ICD10 code(s) *(required)*

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Preoperative Diagnosis: ______________________________

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HISTORY: Pertinent clinical findings and / or diagram

Biohazards	Previous Specimens	Previous Cytology
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Date __________	Date __________	Date __________

Specimens / Sites:

A. ______________________________

B. ______________________________

C. ______________________________

D. ______________________________

E. ______________________________

F. ______________________________