Pathology Associates services

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Suite 1212
Charlotte, NC 28262

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800-524-6779
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CONSULTATION REQUEST

Patient Name (Last, First, MI)		
Street Address		
City	State	Zip
SS#	DOB	Sex M F
Hospital ID	Patient's Telephone No.	

Billing: ☐ **Bill Patient** | ☐ **Bill Patient's Insurance** (attach complete information) | ☐ **Bill Facility**
Name of Facility _____
To the Attention of _____
Address _____
Address _____

Comments regarding billing:

Your Case Number:	Slides Labeled / Qty	Blocks Labeled / Qty	Tissue Fixation	Other materials submitted

Date:	Pathologist/Specialty requested for consultation:	☐ Check here if you are submitting **additional** materials/information at our Pathologist's request.

Case History (or include a separate enclosure letter):

Return with Specimen - Lab