



CELLIGENT DIAGNOSTICS

Pathology Associates Services

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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: <input type="checkbox"/> Bill Patient	<input type="checkbox"/> Bill Patient's Insurance (attach complete information)	<input type="checkbox"/> Bill Facility Name of Facility _____ To the Attention of _____ Address _____ Address _____
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Comments regarding billing:

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

Date:	Pathologist/Specialty requested for consultation:	<input type="checkbox"/> Check here if you are submitting additional materials/information at our Pathologist's request.
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Case History (or include a separate enclosure letter):

Return with Specimen - Lab