Exova Diagnostics
11331 James Watt Dr.
Bldg. 300A El Paso Tx, 79936
Phone No. (915) 944-1299
Fax No. (833) 916-0048

Pathology Consultation Request

☐ External ☐ Internal

SURGICAL PATHOLOGY REPORT

1. Clinical Information 2. Pathology Report 3. Face Sheet (Front and Back Copy of the Patients Insurance Card and Demographic Information) 4. Providers Signature

PATIENT INFORMATION

Last Name _____

First Name _____ M.I._____

DOB _____/_____/_____ Gender: ☐ Male ☐ Female

Address _____

City _____ State _____ ZIP _____

Phone _____ Patient ID _____

PROVIDER INFORMATION

Authorized Provider Signature Date

Please Fax Duplicate Report to Additional Provider Fax

BILLING INFORMATION

Bill to: ☐ Insurance ☐ Medicare ☐ Referring Facility (Hospital/Client) ☐ Split Billing – Client (TC) and Insurance (PC) ☐ Patient

Patient Status: ☐ Inpatient (Hospital) ☐ Outpatient (Hospital) Non-Hospital ☐ ASC ☐ Prior Authorization # _____

CLINICAL INFORMATION (Please include/ attach a list of diagnoses of prior biopsies and the most recent biopsy, if possible)

Patient Clinical History/Diagnosis: _____

_____

ICD-10 Codes: _____

Date Collected _____/_____/_____ Time Collected _____ : _____ ☐ AM ☐ PM Specimen ID _____

CONSULTATION REQUEST

Consultation Requested By: _____ Requestor Name: _____

Requestor Phone Number: _____ Requestor Email: _____

☐ Routine Consultation
TAT: 3-5 days M-F

☐ STAT Post Transplant
TAT: 24 hrs Mon-Sat –WEEKEND STATS -Provide notification, call (915) 944-1299 by 4:30 PM Friday

TRANSPLANT? ☐ Yes ☐ No If Yes, diagnosis at time of transplant? _____

MATERIALS SUBMITTED

BLOCKS

# of Blocks _____

Tissue Type _____

SLIDES

Stained _____ Stain Type _____

Unstained _____

BLOCKS

# of Blocks _____

Tissue Type _____

SLIDES

Stained _____ Stain Type _____

Unstained _____

LABORATORY USE ONLY