PATHOLOGY CONSULTANTS
specialized diagnostic services

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Greenville, South Carolina 29605
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Accession #

TISSUE EXAMINATION

REFERRED BY

Patient (Last, First, M) _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Age** _____ **DOB** _____

Male/Female _____ **SS#** _____

Date Collected: _____ **Time Collected:** _____

Chart # _____

Ordering Physician _____

Copy To: _____

ICD - 10 Code: _____

Specimen Site/Source:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Clinical Impressions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

History (prev. surgery, path numbers or dates): _____

Please attach information or complete below:

Primary Insurance:	**Secondary Insurance:**
Claims Address:	**Claims Address:**
City, State, Zip	**City, State, Zip**
Policy & Group No:	**Policy & Group No:**
Employer:	**Employer:**
Policy Holder:	**Policy Holder:**
Relationship (if other than patient):	**Relationship (if other than patient):**