UR MEDICINE | Labs

ANATOMIC PATHOLOGY
REQUEST FOR OUTSIDE SLIDE REVIEW

REQUIRED (PRINT OR PATIENT LABEL)

Name (Last, First, MI):

Date of Birth:

Sex: (Circle) M F

MRN:

Indicate primary (1) and secondary (2) insurance

- ☐ Aetna
- ☐ Blue Choice/Shield
- ☐ Blue Choice
- ☐ Blue Choice Medicare
- ☐ Medicaid
- ☐ Medicare
- ☐ MVP
- ☐ MVP Gold
- ☐ Other: _____

1. Subscriber ID: _____

Subscriber's Name: _____

Relationship to Subscriber: _____

2. Secondary Subscriber: _____

Subscriber's Name: _____

Relationship to Subscriber: _____

Date of request: _____

Ordering provider name (print):

_____

Ordering provider signature (required):

_____

Deliver or FAX request for slide review to:

AP Consult Team

PHONE (585) 275-3191, option 7

FAX (585) 276-1555

RELEVANT CLINICAL HISTORY (REQUIRED):

Patient's next appointment date/time: _____

For Pathology office use:

DOS: _____ Visit #: _____ Assign to: _____

Outside Institution	# Slides	# Blocks	Outisde Specimen ID#	Collection Date	Source