Practice Name _____
Practice Street _____
City _____ State ____ Zip_____
Phone _____

Consolidated Pathology Consultants

Ph: 847-996-1030 Fax: 847-996-0791

Patient					**Billing** ☐ **Insurance** ☐ **Account** ☐ **Patient**
Name (Last, First)					Responsible party (Last, First) [ ]Self [ ]Child [ ]Spouse [ ]Other _____
Patient ID or SSN			Office MRN		Address
Date of Birth		Male [ ] Female [ ]	Collection Date		City / State / Zip
Send additional report to:			Fax #		Patient Phone # ( ) -
ICD10					Medicare ID# with Suffix
					Primary Insurance Name and Plan
Request	[ ] Slide Consultation [ ] Slide Preparation [√] Complete Service				Policy ID # Group ID
Specimen Site(s)					**Please attach a copy of front and back of insurance card and patient demographic information sheet**

	Procedure	Margins	Clinical Impression / Information
1 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	
2 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	
3 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	
4 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	
5 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	
6 [ ] DIF [ ] PAS [ ] Aerobic culture [ ] Anaerobic culture [ ] Fungal culture	[ ] Biopsy [ ] Curetting [ ] Punch [ ] Shave [ ] Excision	☐	

Physician Signature:	Date:

28100 N. Ashley Circle, suite 106, Liberyville IL 60048