2001 Webber St. Sarasota, FL 34239; www.sarapath.com

Please Submit Request Form: by clicking submit below or fax to (941) 362-8944; Call (941) 362-8917 if there are any questions

REQUEST FOR SARAPATH DIAGNOSTICS PATHOLOGY CONSULT

(on slides prepared elsewhere)

SaraPath Internal Use Only	Request Processed By:
Date Consult Requested:	Date Consult Needed By:

List below any physician or patient instructions provided to identify the case(s) for consult, and indicate if original slides or blocks were requested: ☐ Original Slide(s) ☐ Blocks

_____ as the ordering provider is requesting that SaraPath Diagnostics perform a pathology consult for treatment purposes on the below referenced patient and to contact the custodial facility listed below to obtain the patient's slides, blocks and medical reports as needed for the consult.

PATIENT BILLING INFORMATION

Patient Name (Last Name, First, M.I.)	Patient Sex ☐ Male ☐ Female	Date of Service (MM/DD/YYYY)
Parent or Guardian if Patient is a Minor (Last Name, First)	Patient Date of Birth (MM/DD/YYYY)	Patient Social Security Number
Patient Address	Patient Home Phone Number	Patient Cell Phone Number
Patient City, State	Patient Zip Code	Patient Fax Number
Patient's Insurance Provider (*enter "attached" if copy of patient info sent)*	Policy Holder Name (if different)	Date of Birth of Policy Holder
Insurance Provider Address	Group Number	Policy Number
City, State Zip Code	Insurance Provider Phone Number	Copy of Insurance Card or Face Sheet Sent/Attached? ☐ Yes ☐ No

REQUESTING PHYSICIAN INFORMATION

Physician's Name:	Office Contact Name and Phone #:	Office Fax Number
Instructions and Other Information:		

PATIENT SLIDES AND OTHER RECORDS - CONTACT INFORMATION FOR CUSTODIAL FACILITY

Name of Custodial Facility:	Address of Custodial Facility:	Delivery Method - List SaraPath FedEx # or SaraPath Courier: FedEx #: SP Phone #: (941) 362-8917
Facility Contact Name and Phone #:	Instructions and Other Information:	Date To Be Delivered: If FedEx Delivery (1, 2 or 3 Day):

PATIENT MEDICAL RECORDS FOR THE CONSULT

**Attach copy of patient's initial pathology report ORIGINAL DATE OF SERVICE: ORIGINAL PATHOLOGY CASE #: ORIGINAL SLIDES #: OTHER INFO:	**Attach copy of patient's initial pathology report ORIGINAL DATE OF SERVICE: ORIGINAL PATHOLOGY CASE #: ORIGINAL SLIDES #: OTHER INFO:	**Attach copy of patient's initial pathology report ORIGINAL DATE OF SERVICE: ORIGINAL PATHOLOGY CASE #: ORIGINAL SLIDES #: OTHER INFO:

ADDITIONAL MATERIALS REQUESTED

BLOCKS: # RECUT SLIDES: # SARAPATH CASE: # OTHER INFO:	BLOCKS: # RECUT SLIDES: # SARAPATH CASE: # OTHER INFO:	BLOCKS: # RECUT SLIDES: # SARAPATH CASE: # OTHER INFO:

PHYSICIAN ORDER AND SIGNATURE

By signing this form, the eligible ordering provider hereby authorizes the order for the consult and acknowledges that the patient and /or the insurance company are responsible for payment for the services ordered, including a fee for transport of the patient's slides and blocks between the custodial facility and SaraPath by Federal Express or other carrier.

Signature of Physician or Physician's Representative _____ Date _____

Submit