SaraPath DIAGNOSTICS

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

SENDOUT REQUEST FOR MEDICAL CONSULT

(on slides prepared by SaraPath)

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

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

**Consult Facility:
Please fax a copy of completed report to (941) 362-8971

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

The ☐ Patient, ☐ Physician, _____ has requested that SaraPath Diagnostics as records custodian send the patient's slides, blocks, and medical records to the below listed facility for consult or treatment purposes. SaraPath is not requesting this service and is not responsible for the associated charges. All medical slides and blocks are the custodial property of SaraPath and are irreplaceable. Do not forward or release slides or blocks to another party or dispose of materials without the written consent of SaraPath Diagnostics. Patient materials must be returned to the above address within 30 days via a traceable carrier, unless SaraPath is notified in writing.

PATIENT 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 Street 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 insurance info sent*)
Policy Holder Name (if different):
Date of Birth of Policy Holder:
Insurance Provider Address
Group Number:
Policy Number:
Insurance City, State:
Insurance Zip Code:
Insurance Provider Phone Number:
Copy of Insurance Card or Face Sheet Attached?: ☐ Yes ☐ No

REQUESTING / TREATING PHYSICIAN INFORMATION

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

MEDICAL MATERIALS DELIVERED TO

Name of Consult Facility (must be CLIA licensed):
Address of Consult Facility:
Contact Name and Phone #:
Name of Consult Pathologist/Pathology Department:
Instructions and Other Information:

CARRIER TRACKING INFORMATION

FedEx or UPS Tracking ID:
Date Sent:
Delivery (1, 2 or 3 Day):

MEDICAL MATERIALS AND RECORDS RELEASED *(TO BE COMPLETED BY SARAPATH PATHOLOGIST)*

SPECIMEN/CASE #	SPECIMEN/CASE #	SPECIMEN /CASE#
☐ ORIGINAL SLIDES #	☐ ORIGINAL SLIDES #	☐ ORIGINAL SLIDES #
☐ BLOCKS #	☐ BLOCKS #	☐ BLOCKS #
☐ RE-CUT SLIDES #	☐ RE-CUT SLIDES #	☐ RE-CUT SLIDES #
☐ COPY OF PATHOLOGY REPORT	☐ COPY OF PATHOLOGY REPORT	☐ COPY OF PATHOLOGY REPORT
Faxed to	Faxed to	Faxed to
☐ DICTATED LETTER *(ATTACHED)*	☐ DICTATED LETTER *(ATTACHED)*	☐ DICTATED LETTER *(ATTACHED)*
Comments:	Comments:	Comments:
Name of Pathologist Date	Name of Pathologist Date	Name of Pathologist Date
☐ OK to Send	☐ OK to Send	☐ OK to Send

EXPRESS CARRIER BILLING:
☐ PATIENT RESPONSIBLE ($25 Per Trip) ☐ RECIPIENT RESPONSIBLE CARRIER ACCOUNT #

By signing this form, the patient, physician, or legal representative understands that slides and tissue blocks are irreplaceable and hereby indemnifies and holds SaraPath Diagnostics harmless from any claims, injuries, causes of action, loss and related expenses that may be associated with release of the above described materials. Further, the patient and/or physician acknowledges responsibility for the charges for the consult, including a possible delivery fee for transport of the patient materials between SaraPath and the consult facility by Federal Express or other traceable carrier. This Request For Medical Consult expires 90 days from the Date Requested above.

Signature of Physician or Physician's Representative Date
Signature of Patient or Representative Date

Submit