OPHTHALMIC PATHOLOGY CONSULTATION REQUEST

F.C. BLODI EYE PATHOLOGY LABORATORY

UNIVERSITY OF IOWA HEALTH CARE
Department of Ophthalmology and Visual Sciences

Mailing address: **F.C. Blodi Eye Pathology Laboratory**
University of Iowa
233 Medical Research Ctr
Iowa City, IA 52242-1182

Phone: 319-335-7672 FAX: 319-335-7193

PATIENT INFORMATION

Name: _____

Street: _____

City: _____ **State:** _____

Zip: _____ **Phone #:** _____

Birth Date: _____ **Sex: M / F**

BILLING INFORMATION

Please inform patient they will receive paperwork from the University of Iowa for registration and billing purposes.

☐ **Patient/Pt Insurance (Please provide)**

☐ **Other** _____

SUBMITTING PROVIDER

Physician: _____

Institution/Clinic: _____

Street: _____

City: _____ **St:** _____ **Zip:** _____

Phone #: _____

Fax #: _____

cc report to: _____

@ FAX #: _____

FAX numbers should be HIPAA compliant

TISSUE SUBMITTED: ☐ **RIGHT** ☐ **LEFT** ☐ **BILATERAL**

☐ **Wet Tissue** _____ **Slide(s)** _____ **Block(s)**

Tissue source: _____

_____

_____

_____

_____

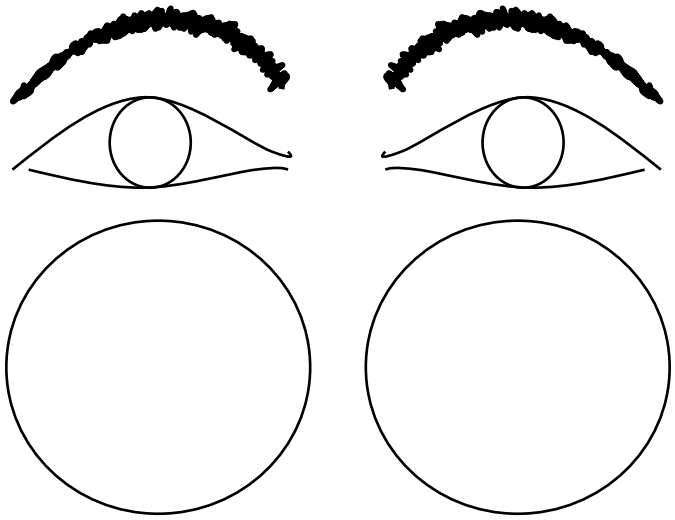
DATE OF TISSUE REMOVAL: _____

PROCEDURE PERFORMED: _____

CLINICAL DIAGNOSIS/ICD-10 CODE:

_____

PLEASE INDICATE TISSUE LOCATION



OD **OS**

CLINICAL Hx: _____

_____

_____

_____

_____

THIS SECTION FOR LAB USE ONLY:

EYE	**DATE REC'D:**	PATIENT STICKER