

## CONFL / Pathology Consult, MCF

### Client Information (required)

Client Name		
Client Account No.		
Client Phone	Client Order No.	
Street Address		
City	State	ZIP Code

### Patient Information (required)

Patient ID (Medical Record No.)	
Patient Name (Last, First Middle)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (mm-dd-yyyy)
Collection Date (mm-dd-yyyy)	Time <input type="checkbox"/> am <input type="checkbox"/> pm

### Submitting Healthcare Professional Information (required)

Submitting/Referring Healthcare Professional Name (Last, First)
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### Fill in only if Call Back is required.

Phone (with area code)	Fax* (with area code)
National Provider Identification (NPI)	

\*Fax number given must be from a fax machine that complies with applicable HIPAA regulation.

<b>MCL Internal Use Only</b>

### Pathology Case Information

**A preliminary/final pathology report is required for each case submitted.**

Client Pathology Case Number	
<input type="checkbox"/> Bone marrow <input type="checkbox"/> Bone, soft tissue, joints <input type="checkbox"/> Breast <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Clinical Pathology <input type="checkbox"/> Cytopathology <input type="checkbox"/> Dermatopathology <input type="checkbox"/> Endocrine (including thyroid) <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Gynecologic <input type="checkbox"/> Head and neck/Oral pathology <input type="checkbox"/> Pancreatobiliary and liver	<input type="checkbox"/> Lymph nodes <input type="checkbox"/> Molecular anatomic pathology <input type="checkbox"/> Molecular hematopathology <input type="checkbox"/> Neuropathology <input type="checkbox"/> Pulmonary <input type="checkbox"/> Renal <input type="checkbox"/> Transplant (cardiac, lung, renal, liver) <input type="checkbox"/> Urologic (GU) To direct case to a specific pathologist, enter name:

### Tissue Specimens Provided (required)

Procedure (eg, biopsy, resection):	Number of slides sent:	List block numbers:
	Tissue source:	

### Reason for Consultation (required)

eg, tumor classification, margin status

### Clinical Notes (recommended)

eg, patient history, lab values

#### Ship specimens to:

Mayo Clinic Laboratories  
4500 San Pablo Road  
Jacksonville, FL 32224

**Customer Service: 800-533-1710**

Visit [www.MayoClinicLabs.com](http://www.MayoClinicLabs.com) for the most up-to-date test and shipping information.

#### Billing Information

- An itemized invoice will be sent each month.
- Payment terms are net 30 days.

Call the Business Office with billing-related questions:  
800-447-6424 (US and Canada)  
507-266-5490 (outside the US)