OCULAR PATHOLOGY CONSULTATION REQUEST

F.C. BLODI EYE PATHOLOGY LABORATORY
Department of Ophthalmology & Visual Sciences
233 Medical Research Center
Iowa City, IA 52242-1182

Phone: 319-335-7095 FAX: 319-335-7193

PATIENT INFORMATION

Name: _____

Street: _____

City: _____ State: _____

Zip: _____ Title: Mr / Mrs / Ms/ Dr

Phone #: _____

Birth Date: _____ Sex: M / F

SS#: _____

SUBMITTING PROVIDER

Physician: _____

Institution/Clinic: _____

Street: _____

City: _____St: _____ Zip: _____

Phone #: _____

Fax #: _____

Please provide a secure fax number
Final report will be faxed to number provided above

BILLING INFORMATION

☐ Patient/Pt Insurance (Please provide)

☐ Other _____

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

TISSUE SUBMITTED ☐ OD ☐ OS ☐ OU

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

Description: _____

_____

_____

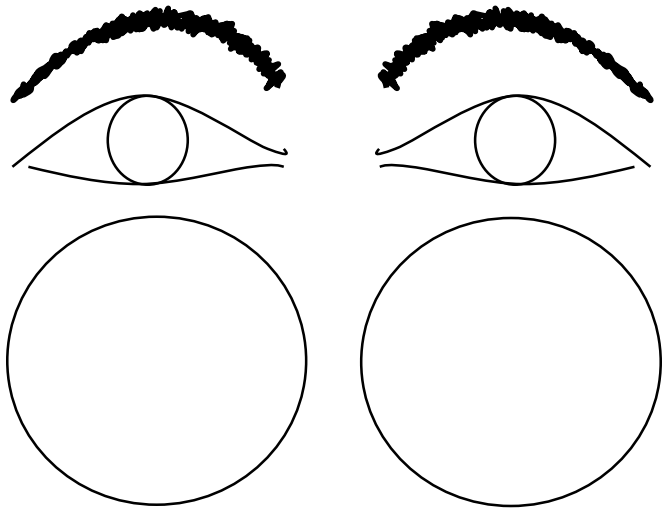
_____

_____

DATE OF TISSUE REMOVAL: _____

PROCEDURE PERFORMED: _____

PLEASE INDICATE TISSUE LOCATION



OD OS

CLINICAL Hx: _____

_____

_____

_____

_____

CLINICAL Dx/IDC-9 Code: _____

FOR UIHC EYEPATH LAB USE ONLY **MRN:**

VERBAL REPORT: TO: DATE/TIME:	DATE REC'D:	O