CONTRIBUTOR'S CONSULTATION REQUEST

PENINSULA PATHOLOGY ASSOCIATES
Service • Technology • Experience

Peninsula Pathology Associates
Phone: 757-594-2160
Fax: 757-594-2951

Pathologists:
David Smith, MD
Michael Schwartz, MD
John Maddox, MD
Theresa Emory, MD
Lucy DeFanti, DO
Damian Tagliente, MD

All cases should be appropriately packaged and submitted to the following address:

Riverside Regional Medical Center
Department of Pathology
500 J. Clyde Morris Blvd.
Newport News, VA 23601

I would like the following physician to provide a consultation: _____

NAME OF PATIENT: (Last, First, Middle) (REQUIRED)		
SEX	AGE	DATE OF BIRTH: (Month/Day/Year) (REQUIRED)

MATERIALS FORWARDED:

- O Clinical information (Including any endoscopic photographs and/or reports) (REQUIRED)
- O Surgical Pathology Report (REQUIRED)
- O Slides (REQUIRED)
- O Blocks or Wet tissue
- O **PLEASE ATTACH COPY OF INSURANCE INFORMATION/FACE SHEET**

CASE IDENTIFICATION:

Specific Biopsy Site or Organ (REQUIRED) _____

Surgical Pathology Accession Number(s) _____

_____

Cytology Accession Number(s) _____

CONTRIBUTOR'S WORKING DIAGNOSIS AND QUESTIONS:

CLINICAL HISTORY: Include location, size, symptoms, duration, physical and laboratory findings, type and date of operation(s) and/or other treatment:

NAME OF CONTRIBUTOR:	TELEPHONE NUMBER:	FAX NUMBER:
NAME OF FACILITY:		OPERATIONAL HOURS:
BUSINESS ADDRESS:		

I certify to the best of my knowledge and belief that no litigation or claim of professional negligence involving the medical care and diagnosis of this patient has been or is about to be filed.

SIGNATURE OF CONTRIBUTOR _____

DATE REQUEST FORWARDED _____