DATE

MRN

NAME

BIRTH DATE

IF NO LABEL, PLEASE PRINT DATE, MRN, & NAME

PATIENT IDENTIFIER MUST BE ON EACH SPECIMEN CONTAINER

Page 1 of 1

H-2 PATHOLOGY CONSULTATION

EYE PATHOLOGY CONSULTATION REQUEST

Department of Ophthalmology & Visual Sciences
F. C. Blodi Eye Pathology Laboratory
233 Medical Research Center
Iowa City, IA 52242-1182

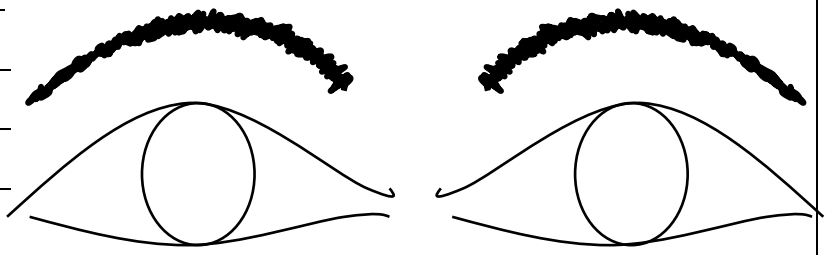
319-335-7672 (phone); 319-335-7193 (fax)

http://www.medicine.uiowa.edu/eye/path-lab/

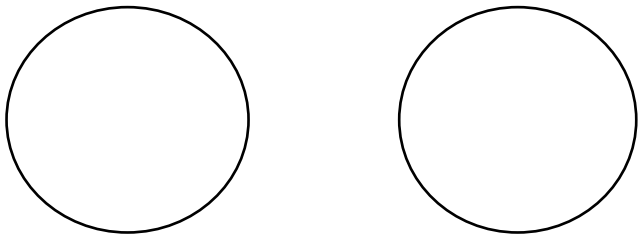
Attending physician Name:	CC Copy of Report to:	Procedure Location (circle one): Minor Room / Clinic / Main OR / ASC / IRL / SFCH
Date Collected:	Time Collected:	• This completed form must be scanned in EPIC •

Tissue Submitted: ☐ **RIGHT** ☐ **LEFT** ☐ **BILATERAL**

Tissue Location:



RIGHT **LEFT**



Procedure Performed:

Clinical History:

Clinical Diagnosis/ICD-10 Code(s):

Was a specimen from this case sent to another laboratory? ☐ Yes ☐ No

If yes, select which one(s): ☐ Frozen section ☐ Immunopathology/DIFM ☐ Microbiology ☐ Flow Cytometry ☐ Cytogenetics

EPIC DOWNTIME ONLY:

I, the attending physician, understand and agree that reflex testing may occur per established protocols, as deemed necessary.
If you wish to be contacted before any additional testing such as special stains/procedures are performed, check box below:

☐ I, the attending physician, wish to be contacted before any additional procedures are performed. I understand that this may delay the handling or diagnosis of this case. I further understand that I will be required to generate an additional order for any procedure(s) I request.

Physician Signature (required during downtime) | Date | Time

LAB USE ONLY:

Accession Number:	Date/Time Received:	Flags:
EYE		