

# OPHTHALMIC PATHOLOGY CONSULTATION REQUEST

## F.C. BLODI EYE PATHOLOGY LABORATORY

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

Phone: 319-335-7609 FAX: 319-335-7193



Department of Ophthalmology  
and Visual Sciences

### 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 \_\_\_\_\_

TISSUE SUBMITTED:  RIGHT  LEFT  BILATERAL

Wet Tissue \_\_\_\_\_ Slide(s) \_\_\_\_\_ Block(s)

Tissue source: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE OF TISSUE REMOVAL: \_\_\_\_\_

PROCEDURE PERFORMED: \_\_\_\_\_

CLINICAL DIAGNOSIS/ICD-10 CODE: \_\_\_\_\_  
\_\_\_\_\_

### SUBMITTING PROVIDER

Physician: \_\_\_\_\_

Institution/Clinic: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

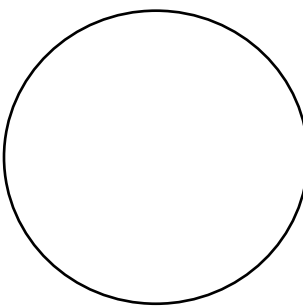
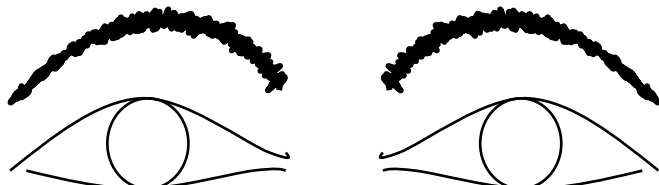
Fax #: \_\_\_\_\_

FAX final report to: \_\_\_\_\_

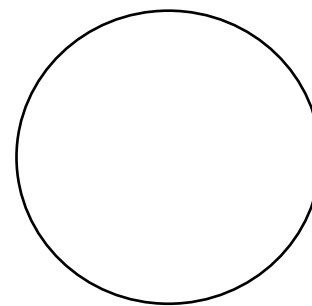
@ FAX #: \_\_\_\_\_

FAX numbers should be HIPAA compliant

### PLEASE INDICATE TISSUE LOCATION



OD



OS

CLINICAL Hx: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### THIS SECTION FOR LAB USE ONLY:

EYE

DATE REC'D:

PATIENT STICKER