CALIFORNIA TUMOR TISSUE REGISTRY

CONTRIBUTOR’S CONSULTATION REQUEST

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Patient (Last, First, Middle)  Click here to enter text.  **CASE IDENTIFICATION:**  Surgical Path Accession No.  Click here to enter text.  Specific Biopsy Site or Organ  Click here to enter text. MATERIALS FORWARDED Clinical Information  Slides  Blocks or Wet Tissue  Other | Sex  Click here to enter text. | Race  Click here to enter text. | Age  **REASON FOR SUBMISSION:**  Consultation (You may keep material)  Consultation (Please return material)  Donation of case to CTTR  Click here to enter text. | Date of Birth (Month, Day, Year)  Click here to enter text. |

Date: Click here to enter a date. Pathologist Requesting Consult NPI #

CLINICAL HISTORY: Include Symptoms, Duration, Physical and Laboratory Findings, type and Date of Operation, and/or other treatment.

Click here to enter text.

CONTRIBUTOR’S PRELIMINARY REPORT LOCATION AND SIZE OF LESION:

(May be incomplete) AND WORKING DIAGNOSIS:

Click here to enter text.

Click here to enter text.

Name of Contributor:Click here to enter text. Telephone Number: Click here to enter text.

Name of the person filling out this form: Click here to enter text.

Name of Facility:Click here to enter text. Telefax Number: Click here to enter text.

Business Address:

***I understand that if CTTR bills the patients insurance as requested***

***by the pathologist requesting this consult above and insurance***

***is denied, CTTR is to bill facility name above for payment.***

***Please initial here*** Click here to enter text.

**Billing Information is REQUIRED before the consult is read**:

**Bill patients insurance I have provided the billing Info & Authorization enclosed for this consultation.**

**Bill Pathologist/Contributor**

**Bill Hospital**

**No Billing Required-Donated Case**

Click here to enter text.