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 OrganClick here to enter text.MATERIALS FORWARDED[ ]  Clinical Information[ ]  Slides[ ]  Blocks or Wet Tissue[ ]  Other | SexClick here to enter text. | RaceClick here to enter text. | Age**REASON FOR SUBMISSION:**[ ]  Consultation (You may keep material)[ ]  Consultation (Please return material)[ ]  Donation of case to CTTRClick 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.