Interior Health

ANATOMICAL PATHOLOGY (AP IH) CONSULT / REVIEW REQUEST FORM

Patient Name *(last)* _____

(first) _____

DOB *(dd / mmm / yyyy)* _____

PHN _____

IH USE ONLY MRN _____

Account / Visit _____

KGH Administration Office:
Email kghlabapclericalstaff@interiorhealth.ca
Phone 250-862-4000 Ext. 24433
Fax 250-862-4051

Specimen # for consult / review	☐ Gastrointestinal / Liver Pathology ☐ Gynecologic Pathology ☐ Dermatopathology
Specimen type	☐ Cytopathology ☐ Soft tissue / Bone Pathology ☐ Other _____

Requesting Physician / MSP #	**REQUIRED – Reason for requested review or consult including history** ☐ **Letter attached (optional)**
Request initiated by: ☐ **Pathologist** ☐ **Clinician**	
Signature (Required)	
Date (dd / mmm / yyyy)	
Contact number for report / fax	
Copies to (name / phone / MSP #) Note: Clinician consults require a copy to the originating Pathologist 1. _____ 2. _____ 3. _____	

LAB USE ONLY

Originating Site

Notes: forward all slides and blocks to KGH on requested case at the time of request.

Date sent (dd / mmm / yyyy): _____

Materials sent: number of slides: _____
number of blocks: _____

Case pathologist: _____

Receiving Site: ☐ **KGH** ☐ **RIH**

Date received (dd / mmm / yyyy): _____

Materials sent: number of slides: _____
number of blocks: _____

Assigned consult / review pathologist: _____

Consult / review case number: _____

Date returned (dd / mmm / yyyy): _____

Additional comments:

Clear Form | Print Form | Save Form | Submit Form