CALIFORNIA TUMOR TISSUE REGISTRY
CONTRIBUTOR'S CONSULTATION REQUEST

Name of Patient (Last, First, Middle)	Sex	Race	Age	Date of Birth (Month, Day, Year)

MATERIALS FORWARDED

____ Clinical Information

____ Slides

____ Blocks or Wet Tissue

____ Other

CASE IDENTIFICATION:

Surgical Path Accession No.

_____

Specific Biopsy Site or Organ

_____

REASON FOR SUBMISSION:

___ Consultation (You may keep material)

___ Consultation (Please return material)

___ Donation of case to CTTR

Date of Service : _____ Date sent: _____

Pathologist Requesting Consult NPI #_____

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

CONTRIBUTOR'S PRELIMINARY REPORT
(May be incomplete) AND WORKING DIAGNOSIS:

LOCATION AND SIZE OF LESION:

Name of Contributor: _____
Name of the person filling out this form_____
Name of Facility: _____

Business Address: _____

_____

_____
City State Zip

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. ____ Initials

Telephone Number: _____
Telefax Number: _____

Billing Information is REQUIRED before the consult is read:

___ Bill patients insurance I have provided the billing Info & Authorization is enclosed for this consultation to be billed to patients insurance.

___ Bill Pathologist/Contributor

___ Bill Hospital

___ No Billing Required-Donated Case

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