AIP
ASSOCIATES IN
PATHOLOGY, S.C.

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Consultation/Materials Request Form

Today's Date: _____

Requesting Physician: _____

Patient's Name: _____

Patient's DOB: _____

AIP accession #: _____

Please Check All That Apply:

☐ Consultation at AIP
☐ Consultation at Outside Facility (Please Verify Facility Below)
Patient Appointment ☐ Yes ☐ No Date_____

Facility Name: _____
Attention: _____
Facility Address: _____
_____
Facility Phone #: _____
Patient #: _____

Additional Comments:
_____
_____
_____

☐ By checking this box, I understand any charges associated with this consultation may be billed to my facility.

Physician's Signature: _____