The Delta Pathology Group, L.L.C.

Alexandria
211 Fourth St.
Alexandria, LA 71301
318-769- Tel
318-769-3 Fax

Lafayette
4801 Ambassador Caffery
Lafayette, LA 70508
337-470-4 Tel
337-470-4051 Fax

Monroe
309 Jackson St.
Monroe, LA 71201
318-966-4105 Tel
318-966-4423 Fax

Greater New Orleans
1141 Whitney Ave. Bldg 3
Gretna, LA 70056
504-361-3757 Tel
504-361-3132 Fax

Shreveport
2915 Missouri Ave.
Shreveport, LA 71109
318-621-8820 Tel
318-212-4189 Fax

Toll Free:
1-800-530-5088

BREAST PATHOLOGY

PATIENT INFORMATION

Last Name First MI

Address

City State ZIP

Social Security Number

Medical Record Number Phone Number

Date of Birth ___ Male ___ Female

Physician Last Name, First, MI

Additional Report To:

Nurse

BILLING INFORMATION

BILL TO: ___ Patient ___ Medicare ___ Medicaid ___ Other

Subscriber Name Primary Care Physician

Medicare Number Suffix(es)

Medicaid Number State

Policy Number Group Number

Primary Insurance Company

Address

Secondary Insurance Company Policy Number Group number

Address

REQUIRED INFORMATION

COLLECTION DATE	ROOM # (IF USED)	SURGICAL EXCISION TIME	TIME PLACED IN FORMALIN

REQUEST FOR BREAST PATHOLOGY EXAMINATION

__ GROSS AND MICROSCOPIC EXAM __ FLOW CYTOMETRY
__ FROZEN SECTION __ GROSS EXAM ONLY
__ OTHER ____________________________________

____

CLINICAL INFORMATION

SPECIMEN(S) SUBMITTED

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

CLINICAL DIAGNOSIS / PATIENT HISTORY

LAB USE ONLY | FS DIAGNOSIS:

No. of Containers Submitted

LAB USE ONLY – ACCESSION NO.

INITIALS

H&E QC Acceptable _______________ Time In _______________ Time Out _______________ Cryostat temp _______________

The results of the Frozen Section examination were reported to the physician listed above on today's date at the time indicated.