PETROGLYPH
PATHOLOGY SERVICES

REQUEST FOR PETROGLYPH CONSULT

Patient Information:

Last Name	First Name	MI	Date of Birth	Sex
			/ /	M ☐ F ☐

Consultation Information:

Accession Number _____ Date of Service ____/____/____

Specimen _____

Lab/Facility from whom material is to be requested _____

Physician requesting consult _____

Physician's telephone number _____

Reason for consultation _____

_____

_____

Patient Insurance Information:

Primary Insurance:		**Secondary Insurance:**	
Company:		Company:	
Policy Number:		Policy Number:	
Group Number:		Group Number:	

(or attach/fax insurance card/s)

Fax completed form to 505-924-0210