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UT HEALTH SCIENCE CENTER®
SAN ANTONIO

OPHTHALMIC PATHOLOGY LABORATORY
REQUEST FOR CONSULTATION

Date:

Type of Request

E.P. No:_____

Patient ( )
Attending Physician ( )
Pathologist to Pathologist ( )

Date & Time_____

Signature_____

Requested BY:_____

Case Number:_____

Patient Name:_____ DOB:_____ DOS:_____

Number of Slides_____

Blocks:_____

( ) Please return blocks and slides. This is original material and thus a permanent part of the patient record.

( ) Slides are duplicates which you may retain.
Please send a copy of patient history!

Comment:_____

_____

_____

Please send a copy of your report to:

F.W. Scribbick III, MD

210-567-8411

Mail Address: UTHSCSA

7703 Floyd Curl Dr. MC6230 (Room 4.520)

San Antonio, Texas 78229-3900