PATHOLOGY DIAGNOSTIC CONSULTANTS, Inc.

A Division of ORANGE COUNTY PATHOLOGY MEDICAL GROUP, INC.

805 W. La Veta Ave.
Suite 104
Orange, CA 92868

Tel: (714) 288-4044
Fax: (714) 288-4042

Patient's Request for Second Opinion Consult

I authorize and request my treating physician, _____, M.D., to provide Pathology Diagnostic Consultants (a division of Orange County Pathology Medical Group, Inc.), a healthcare provider of anatomic laboratory services, with a Test Order for a Consult interpretation and report concerning my prior pathology specimen(s) collected on or about _____ and reported by _____ (original pathologist) under case number(s) _____.
I agree to pay Pathology Diagnostic Consultants' fee for the second opinion consult.
I also consent to providing a copy of the consult report to the original pathologist and to me.

_____ _____ _____
Patient's Name (Printed): Patient's DOB Phone Number

Address: _____

_____ _____
Signature of Patient **Date**
OR PATIENT REPRESENTATIVE IF PATIENT IS A MINOR
OR AN ADULT UNABLE TO SIGN THIS FORM.

(NOTE: TREATING PHYSICIAN COMPLETES BELOW)

Treating Physician's Test Order for Second-Opinion Consult

To: Pathology Diagnostic Consultants -- (Lisa Kohorn, M.D., Medical Director)

From : _____ _____
Print Physician's Name Phone Number (required)

_____.
(Address)

Test Ordered: Consult interpretation and report on the above-described pathology specimen(s), pursuant to the above executed authorization and consent of my patient or patient representative.

Please send your report to me at my above address and provide a copy of your report to:

- ✓ The above original Pathologist.
- ✓ The Patient (or Patient Representative if patient is a minor or is unable to sign).

Other: _____.

_____ _____
Signature of Ordering Physician **Date**