A Division of NEWPORT HARBOR PATHOLOGY MEDICAL GROUP, INC.

805 W. La Veta Avenue
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 Orange County Pathology Medical Group (a division of Newport Harbor 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 Orange County Pathology Medical Group 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: Orange County Pathology -- (Michael I. Schoen, 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**