CellNetix Consult Request Form

Patient name	
MRN	
Date of birth	
Name of laboratory where slides are located	
Phone of above lab	
Date of original service	
Accession/case number	
ICD-10 code	
Requesting facility	
Requesting physician (printed name)	

_____ _____

Requesting Physician Signature Date

Please FAX to: 206-576-6711