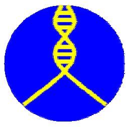

Requisition Form, GenoPath (U.S.A.), Inc.
美国基因病理诊断和谘询公司会诊申请单

Pt's Name: 病人姓名:	Sex: 性别:	Date of Birth or Age: 出生日期或年龄:

Referred by ( ) Physician, ( ) Patient or ( ) Others 会诊申请人：医生 ( )，病人 ( ), 其他人 ( ).	Date of Referral: 送诊日期:

Consultation Report to Be Sent to (Name and Address) 会诊申请人姓名和地址:

Tel. 电话: **Fax** 传真: **E-mail** 电邮:

Preferred Method to Receive the Final Report 请选择接收会诊报告方式:
( ) **Mail** 邮寄, ( ) **Telephone** 电话, ( ) **Fax** 传真, ( ) **E-mail** 电邮.

Clinical History 临床病史

History of present illness 现病史:

Past history 过去史:

Important family and social history (smoking, etc.) 相关家族史和生活史(如吸烟等):

Preliminary Pathologic Diagnosis 初步病理诊断或印象:

(Important: original pathology report should be included for each consultation 注意:会诊申请单务请附上原始病理报告)

Main Question(s) to Be Addressed and Purpose for Consultation 会诊主要问题和目的:

Materials Submitted for Consultation 送诊标本和片子

Slides (number) 切片 __________ 张; **No.** 编号____

Blocks (number) 石蜡包块__________ 张; **No.** 编号____

X-Rays (number) X 光片___________ 张; **Other** 其它:

Payment Method (please check) 请选择付费方式

( ) **Cash** 现金
( ) **Check** 支票
( ) **Credit card** 信用卡
( ) **Money order** 汇款或汇票
( ) **Health insurance (Require pre-arrangement)** 医疗保险(需事先安排)
( ) **Other method** 其它方式

Mailing Address 邮寄地址: 北京市石景山区京原路 **5** 号北京朝阳医院(京西院区)基因病理诊断中心, 邮编:**100043**, 电话:**010-51718025,8075,8015;** 美国: **GenoPath (U.S.A.), Inc., Receiving Department., 31 Wren Field Ln, Pittsford, NY 14534, U.S.A. Tel.** 电话: **585 218 0581; Fax** 传真: **716 218 0581.E-mail** 电邮: support@genopathusa.com, **Website** 公司网址: www.genopathusa.com