

CONSULT SERVICE PROBLEM FORM



**Michigan Medicine
Laboratories (MLabs)**

mllabs.umich.edu
800.862.7284
FAX: 734.936.0755

MLabs/MM Staff Name: _____ Receipt Date: _____ Time: _____

Place barcoded test label here or fill in:

Patient Name: Last _____ First _____ MI _____

Patient Reg or MRN: _____

Client Name or Location: _____ Client Code: _____ Client Ward: _____

SPECIMEN SHIPMENTS ONLY:

N-LNC Specimen Processing, 2800 Plymouth Rd,
Bldg 35, Ann Arbor, MI 48109-2800

Information was not included with materials submitted for testing, the materials or requisition require correction to information, or the materials or requisition are missing patient identifiers. Please provide missing or corrected information.

MATERIAL(S) RECEIVED

Block Stained Slide(s) Unstained Slide(s) Other: _____

Case type: Consult Transfer IHC (TO/TI) Additional Materials

| MISSING OR INCORRECT INFORMATION | MISSING | CORRECTED | INFORMATION | NOTES |
|---|--------------------------|--------------------------|-------------|-------|
| PATIENT SEX | <input type="checkbox"/> | <input type="checkbox"/> | | |
| PATIENT DATE OF BIRTH | <input type="checkbox"/> | <input type="checkbox"/> | | |
| PATIENT REGISTRATION OR MEDICAL RECORD NUMBER (MRN) | <input type="checkbox"/> | <input type="checkbox"/> | | |
| CLIENT ACCESSION NUMBER OR BLOCK ID | <input type="checkbox"/> | <input type="checkbox"/> | | |
| REFERRING PATHOLOGIST | <input type="checkbox"/> | <input type="checkbox"/> | | |
| TISSUE COLLECTION DATE | <input type="checkbox"/> | <input type="checkbox"/> | | |
| BILL TO INSTRUCTIONS (CLIENT/PATIENT/PATIENT INSURANCE) | <input type="checkbox"/> | <input type="checkbox"/> | | |
| INSURANCE/DEMOGRAPHIC FACESHEET | <input type="checkbox"/> | <input type="checkbox"/> | | |
| PATHOLOGY REPORT | <input type="checkbox"/> | <input type="checkbox"/> | | |
| OTHER PROBLEM | | | | |
| MATERIALS RECEIVED DISCREPANCY | <input type="checkbox"/> | | | |
| DAMAGED MATERIALS | <input type="checkbox"/> | | | |
| REQUIRED BLOCK NOT RECEIVED | <input type="checkbox"/> | | | |
| OTHER: | <input type="checkbox"/> | | | |

Request Taken By MLabs/Pathology Staff: _____ Date/Time: _____ MLabs/Pathology Staff: _____ Date/Time: _____

Approved by (Client/Provider): _____ Title: _____

Information communicated to MLabs/MM Lab by telephone or email