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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>THE JOINT PATHOLOGY CENTER<br/>CONSULTATION REQUEST FORM</b><br><i>(Please Complete All "Required" Sections)</i><br><i>Note: Incomplete information could delay processing.</i>                                                                                                                                                                                                                                                                                                 |  |                                                                 |  | <b>ATTN:</b> The Joint Pathology Center<br>Case Accessioning<br>606 Stephen Sitter Avenue<br>Silver Spring, MD 20910-1290                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| <b>PATIENT INFORMATION (Required)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                 |  | 9. ETHNICITY:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |
| 1. LAST NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 2. FIRST:                                                       |  | 3. MIDDLE INITIAL: <input type="checkbox"/> Hispanic or Latino                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| 4. AGE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 6. DATE OF BIRTH:                                               |  | 10. RACE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| 5. SEX:<br><input type="checkbox"/> Male <input type="checkbox"/> Female                                                                                                                                                                                                                                                                                                                                                                                                           |  | Month:      Day:      Year:<br>(MM)      (DD)      (YYYY)       |  | <input type="checkbox"/> American Indian or Alaska Native<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Native Hawaiian or Other Pacific Islander<br><input type="checkbox"/> White                                                                                                                                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | Please provide SSN OR DODID<br>7. SSN: _____<br>8. DODID: _____ |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 11. If the patient previously had consultation with the JPC or AFIP please provide the JPC/AFIP Accession No.:                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| <b>MATERIALS FORWARDED (Required)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 12. Case(s) for Consultation Surgical No./Autopsy No.:                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                 |  | 15. Subspecialty Requested for Consultation (Please direct to appropriate subspecialty)                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| 13. Case(s) for Comparison Surgical No./Autopsy No.:<br><i>(No Report Will Be Issued)</i>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                 |  | <input type="checkbox"/> Dermatopathology <input type="checkbox"/> GYN and Breast<br><input type="checkbox"/> GI and Liver <input type="checkbox"/> Endocrine<br><input type="checkbox"/> Oral (Head and Neck)<br><input type="checkbox"/> Hematopathology <input type="checkbox"/> Genitourinary<br><input type="checkbox"/> Nephropathology <input type="checkbox"/> Neuropathology<br><input type="checkbox"/> Soft Tissue and Bone<br><input type="checkbox"/> Pulmonary and Mediastinal<br><input type="checkbox"/> Other: _____ |  |
| NOTE: FOR ORTHOPEDIC, PULMONARY, AND NEUROPATHOLOGY CONSULTATIONS, IMAGING STUDIES MUST BE SUBMITTED ON DISK <i>(please protect against breakage)</i>                                                                                                                                                                                                                                                                                                                              |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| <input type="checkbox"/> Surgical Pathology Report (req'd) <input type="checkbox"/> Clinical Information <input type="checkbox"/> Disk<br><input type="checkbox"/> Autopsy Report (required for autopsy brain and heart examination) <input type="checkbox"/> Formalin Fixed Tissue<br><input type="checkbox"/> Slides (req'd) <input type="checkbox"/> Tissue for DIF<br><input type="checkbox"/> Blocks <input type="checkbox"/> Tissue for EM<br><input type="checkbox"/> Other |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| Specimen Containers must be labeled with two identifiers, such as Patient Name and SSN/D.O.B or Surgical or Autopsy Number.                                                                                                                                                                                                                                                                                                                                                        |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 14. ORGAN: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                 |  | 16. Material Disposition Selection                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                 |  | <input type="checkbox"/> I am requesting return of slides <i>(other than H&amp;E slides)</i><br><input type="checkbox"/> I am requesting return of blocks.                                                                                                                                                                                                                                                                                                                                                                            |  |
| 17. WORKING DIAGNOSIS / REASON FOR CONSULTATION: <i>Please include any specific questions/issues to be addressed. (Required)</i>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 18. CLINICAL HISTORY: <i>Include: Location, Size, Symptoms, Duration, Physical and Laboratory Findings, Type and Date of Operation(s) and/or other Treatment.</i>                                                                                                                                                                                                                                                                                                                  |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| <b>19. SUBMITTING PATHOLOGIST INFORMATION (Required)</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| SUBMITTING PATHOLOGIST NAME: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| FACILITY NAME: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| BUSINESS ADDRESS: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| CITY: _____ STATE: _____ COUNTRY: _____ ZIP CODE: _____                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| PATHOLOGIST PHONE: _____ EXT: _____ ADMINISTRATIVE PHONE: _____ EXT: _____                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| FAX: _____ SUBMITTING PATHOLOGIST EMAIL: _____                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |

## IMPORTANT

Have you enclosed a legible summary of the clinical findings, laboratory data, operative findings or report, and specific treatment? Clinical or gross photos, pertinent X-rays, CT scans, MRI scans, echograms, angiograms, and similiar diagnostic studies add substantially to the education value of the case. They are highly desired by some JPC sub-specialties and required by others.

## 20. COMMENTS AND REQUESTS

## JPC RETENTION POLICY

1. MICROSCOPIC SLIDES SUBMITTED WITH EACH CASE ARE RETAINED PERMANENTLY. Under certain circumstances original slides may be returned to the Submitting Institution if requested by the Submitting Institution and approved by the JPC.
2. Blocks are retained for a minimum of ten (10) years, unless return is requested by the Submitting Institution at the time the case is submitted. The Submitting Institutions may request return or loan of blocks at some later time. If blocks are returned, then JPC will retain representative diagnostic material.
3. Other pathologic material, X-rays, CT scans, MRI scans, echograms, angiograms, photographs, and similar diagnostic studies may be retained for education and research or discarded.

## PRIVACY ACT STATEMENT

1. AUTHORITY: 5 U.S.C. 301 and 10 U.S.C 176, 5 U.S.C. 552a, 10 U.S.C 1079b.
2. PRINCIPAL PURPOSES: Medical information received is considered during the consultative process and is used to form a database for education and research in pathology. Other patient information is used for filing and retrieval of consultation records. Information concerning the contributor is used to maintain contributor mailing lists.
3.
  - a. In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside the DoD as a routine use as follows.
  - b. Pathology consultation records are tracked in the Pathology Information Management System database for filing and retrieval of records, medical research, and statistical purposes. Individual consultation records may be released to the submitting medical care provider (physician, veterinarian), when required by law or as otherwise permitted by 45 C.F.R. 164.
  - c. The DoD 'Blanket Routine Uses' set forth at the beginning of the Army's compilation of systems of records notices also apply to this system.
  - d. Pathology consultation records contain individually identifiable health information. The DoD Health Information Privacy Regulation (DoD 6025.18-R) issued pursuant to the Health Insurance Portability and Accountability Act of 1996, applies to most such health information. DoD 6025.18-R may place additional procedural requirements on the uses and disclosures of such information beyond those found in the Privacy Act of 1974 or mentioned in this Privacy Act Notice.
4. PROVISION OF INFORMATION: The provision of patient information requested on this form is voluntary. However, if the information is not furnished, a consultation may not be possible. If so, the material submitted may be returned at the discretion of the JPC without a consultation.