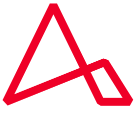

Arkana
Laboratories

Affix patient sticker here

Consult/Stain Request Form

Patient Name: ______________________ Date of Birth (MMDDYYYY): ____________ **Social Security #:** ____________

Gender: ☐ M ☐ F **Race:** ________ **Surgical Number:** ______________ **Collection Date:** ______________

Address: ______________________________________ **Phone #:** ______________________

Referring Facility: ____

Address: ______________________________ **Phone #:** ____________ **Fax #:** ______________

Billing Contact: ______________________________ Consults are billed back to the referring facility.

Materials Submitted For: ______________________ **Specimen Identification:** ______________________

Indication of Biopsy: ____

Past Medical History: ☐ Diabetes ☐ Hypertension ☐ MGUS ☐ Gout ☐ Smoking ☐ Obesity

☐ Other: ____

Brief Clinical History: ____

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10810 Executive Center Drive, Suite 100 Little Rock, Arkansas 72211
Telephone +1 501 604 2695 Fax +1 501 604 2699 support@arkanalabs.com

arkanalabs.com