MICRODIAGNOSTICS
PRIVATE CYTO/HISTOPATHOLOGY LAB

Request form for second medical diagnosis (SECOND OPINION)

How to complete:

1. The first section of this form contains the necessary information for the patient
2. The second section must be completed by your doctor, in case you wish to have the diagnosis paid for by your insurance program.

   Note: It may be that your insurance program doesn't cover the expenses of a second opinion at the request of the patient. Contact your insurance provider to inform yourself on the matter.

3. The third section, in case you wish to have the diagnosis paid for by your insurance program, must also be completed.
4. The last section is a form through which you can request that we provide to you a copy of the results and of your diagnosis, as stated in Article 12 of Law 2472/1997.
5. For any patients that cover the expenses **out of pocket:** Please fill in and print out **Section 1**, the **request to provide a copy of the results** and mail them to us together with the slides (hematoxylin and eosin slides) and paraffin blocks of your histological examinations.

Information for the patient – Section 1

Patient request for pathology diagnosis, individually payable.

Fill in Section 1, to pay with credit card, please contact 2310 232272

6. *If your insurance company covers the costs, the request for the diagnosis should be made by your doctor. Ask him/her to fill in Sections 2 and 3 and submit the documents along with the slides (hematoxylin and eosin slides) and the paraffin blocks of your histological examinations.*

Note*: We may contact the patient and/or the insurance company.*

Patient's name: _____

Address: _____

Address: _____

City: _____ Prefecture: _____Country: _____ P.O _____

Landline: _____ Mobile Phone: _____

Date of Birth: _____ AMKA: _____

Sex: Male ☐ Female☐ E-mail: _____

Patient's reason to request a second diagnosis:

_____

_____

_____

Patient's questions:

_____

_____

_____

_____

_____

Information for the patient – Section 1 (continued)

Do you wish to have a copy of the diagnosis sent to your attending doctor? Yes ☐ No ☐

Doctor's name: _____

Name, Surname, Title

Address: _____

Address: _____

City: _____ Prefecture: _____Country: _____ P.O _____

E-mail: _____

SECOND OPINION ON HISTOPATHOLOGIC EXAMINATION

*** In case you wish to have the diagnosis paid for by your insurance program, this section must be completed by your doctor****

Section 2

☐ The request for this diagnosis has been made by the doctor attending to the case

Name of attending doctor: _____ Reg. Num: _____

Name, Surname,

Address: _____

Address: _____

City: _____ Prefecture: _____Country: _____ P.O _____

Phone number: _____ Fax: _____E-mail:_____

Patient's name: _____ Date of birth: _____

Patient's medical history:

_____

_____

_____

_____

_____

_____

_____

_____

Section 2 (continued)

Reason fort he consultation/specific questions (required)

- ☐ Confirmation of diagnosis aimed at providing treatment
- ☐ Confirmation of disputed diagnosis aimed at providing treatment
- ☐ Solution of dispute between clinical and histopathological indication aimed at providing treatment
- ☐ Other: _____

  _____

Initial diagnosis:

_____

_____

_____

Signature of requesting doctor: _____ Date: _____

SUBMITED MATTERIAL:

Total slide number: Patient/s protocol number:_____

Total block number: Patient/s protocol number:_____

Other Material: _____

Which of the submitted material do you wish to have returned to you? ☐All ☐ None

Do you allow our company to copy and store in its archive your submitted material? ☐Yes ☐ No