

PATHOLOGY CONSULT REQUEST FORM

**Failure to provide the information below will lead to the case being returned without review.*

** For patients being seen at Brigham and Women's Hospital - complete the top section **ONLY**. No signature is required.*

1) PATIENT INFORMATION:

Patient Name: _____ Date of Birth _____
Patient Gender: M F Currently an inpatient? YES NO

2) INSTITUTION/HOSPITAL SENDING CONSULT:

(Contact Person Name) (Phone Number)

(Name of Institution) (Address of Institution)

3) PATHOLOGY ACCESSION/LABEL NUMBER: _____

NUMBER OF BLOCKS _____
NUMBER OF STAINED SLIDES _____ NUMBER OF UNSTAINED SLIDES _____

4) REQUIRED INFORMATION TO BE INCLUDED IN THIS PACKAGE:

- PATIENT DEMOGRAPHICS
- PATIENT INSURANCE INFORMATION
- INSURANCE **AUTHORIZATION** NUMBER (if applicable) _____
- ORIGINAL AND/OR YOUR INSTITUTION'S PATHOLOGY REPORT

5) THIS MATERIAL IS BEING SENT AT THE REQUEST OF:

- A different outside institution/hospital _____ (Name of Facility)
- Brigham and Women's _____ (Name of Physician)

Only complete this section below if the material is being sent at THE REQUEST OF YOUR INSTITUTION

6) WHO SHOULD BE BILLED FOR THE REVIEW OF THIS CASE?

- Patient (Please include billing information) Your institution
- Other (name) _____

7) NAME & NPI NUMBER OF ORDERING/REFERRING PHYSICIAN/PATHOLOGIST:

Full Name of Doctor Email

NPI # Telephone number Fax number

8) Additional Report Recipient (Full Name and Email, if applicable):

9) REQUEST THIS MATERIAL BE REVIEWED BY: _____ (Pathologist Name)

PHYSICIAN SIGNATURE IS REQUIRED

- Check here if there is a letter attached with an authorized signature

PHYSICIAN SIGNATURE HERE