

Consultation Request Form

Consultants for Pathology & Laboratory Medicine, Cedars-Sinai Medical Center
8700 Beverly Blvd., Suite 8725, Los Angeles, CA 90048 Phone: (310) 423-6623; Fax: (310) 423-0122

Facility: _____ Date: _____

Dr. Name: _____ Phone: _____

Address: _____ Fax: _____

_____ E-mail address: _____

The information in this section is mandatory for patient tracking. Missing information could delay review of the case.

Pt. First Name: _____ Last Name: _____

Age: _____ DOB: _____ Sex: M / F S.S. #: _____

Materials Submitted:

Slides: Path #: _____ No.: _____ Blocks: Path #: _____ No.: _____

Slides: Path #: _____ No.: _____ Blocks: Path #: _____ No.: _____

Fluid: Blood Urine Other: _____ Specimen # _____

Site of Lesion: _____ Collection Date: _____

Send bill for this consult to: (Please check one and provide all the information requested.) Cases submitted without patient insurance information will be billed to the referring physician/pathologist or alternatively can be charged against a credit card account. We regret we cannot bill Medicaid outside of CA.

- Referring pathologist:** _____
- Clinician (Name, address, phone number):** _____
- _____
- Bill referring pathologist**
- Credit Card:** (Circle One) VISA MASTERCARD AMERICAN EXPRESS DISCOVER
- Credit Card Number: _____ Expiration Date: _____
- Card Holder Name (Please Print): _____ Signature: _____
- Patient Insurance - Patient (or patient's guardian) Name:** _____
- Address: _____
- _____
- Phone: _____ Social Security #: _____
- Insurance: _____ **(Please provide copy of front/back of insurance card.)**
- Policy #: _____ Group #: _____
- Insurance Company Address: _____
- _____
- Insurance Company Phone #: _____ Referring Pathologist UPIN #: _____

Use one form per case. Enclose a cover letter outlining the clinical history and a copy of the surgical pathology report, even if incomplete (gross description of specimen), to document patient identity as well as slide labeling.