

Consultation Request Form

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Facility: _____ Date: _____
Dr. Name: _____ Phone: _____
Address: _____
_____ Fax: _____

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.: _____
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.