

Consultation Request Form

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Type of Consult -

- Breast Pathology
GI-Hepatic Pathology
GYN Pathology
Head/Neck Pathology
Immunochemistry
Pulmonary Pathology
Other

Facility: Date:
Dr. Name: Phone:
Address: Fax:
NPI:
UPIN:

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 GA.

Referring pathologist:

Clinician (Name, address, phone number):

Credit Card: VISA MASTERCARD AMERICAN EXPRESS DISCOVER (Circle One)

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 #:

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 identify as well as slide labeling.