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 the 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:

☐ Check here if this MD is already registered at Brigham and Women's (has sent previous cases)

____________________________________________________________________________

Doctor full name ___________________________ NPI # ___________________________

____________________________________________________________________________

Telephone number ___________________________ Fax number ____________________

8) REQUEST THIS MATERIAL BE REVIEWED BY: ________________________________ (name of Pathologist)

*PHYSICIAN SIGNATURE IS REQUIRED*

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

PHYSICIAN SIGNATURE HERE

Revised 4/15/15