Beth Israel Deaconess Medical Center

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

PATHOLOGY CONSULT REQUEST FORM

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

1) PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Patient Gender: ☐ M ☐ F Currently an Inpatient (at your institution)? : ☐ YES ☐ NO

2) INSTITUTION/HOSPITAL <u>SENDING</u> CONSULT:

_____

(Contact Person Name) (Phone Number)

_____

(Name of Institution) (Address of Institution)

_____

(Contact Email Address – **Mandatory Field**)

3) WHO SHOULD BE BILLED FOR REVIEW OF THIS CASE?

☐ Patient (please include all required demographic and insurance information as requested below)
☐ Institution

_____

(Billing Address – please indicate the exact billing address and contact)

4) REQUIRED INFORMATION TO BE INCLUDED IN THIS PACKAGE:

☐ PATIENT DEMOGRAPHICS
☐ PATIENT INSURANCE INFORMATION - **REQUIRED** (see Lab Registration form)
☐ INSURANCE AUTHORIZATION NUMBER (if applicable) _____
☐ (ORIGINAL) AND/OR YOUR INSTITUTION'S PATHOLOGY REPORT

5) NAME AND NPI# OF ORDERING/REFERRING PHYSICIAN/PATHOLOGIST:

_____

(Doctor Full Name) (NPI#)

_____

(Telephone Number) (Fax Number – **for final report**)

****PHYSICIAN SIGNATURE IS REQUIRED****

PHYSICIAN SIGNATURE HERE