Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Beth Israel Deaconess Medical Center
Boston, MA 02215
Department of Pathology
Division of Anatomic Pathology

BIDMC OUTSIDE PATHOLOGY CONSULTATION REQUEST FORM

PATIENT INFORMATION:	
Date of Request:	Patient Name:
Patient Date of Birth:	Patient Gender:

SENDING INSTITUTION/HOSPITAL:	
Name of Institution:	Contact Person:
Phone Number:	Email (required):
Fax:	Address:

BILLING INFORMATION:	
Who should be billed for review of this case? (Select **one** and fill only associated fields. Include patient information only if patient is being billed)	
☐ **Patient**	Patient Insurance Plan:
Patient Insurance Member Number/ID:	
☐ **Institution**	
Complete Billing Address:	Billing Contact (full name and email required):

DISEASE GROUP:

☐ Breast	☐ Bone/Soft Tissue	☐ Cardiac	☐ Derm	☐ Renal
☐ Gastrointestinal	☐ Genitourinary	☐ Gynecologic	☐ Head & Neck	☐ Cytology
☐ Hematologic	☐ Liver	☐ Thoracic/Lung	☐ Neurologic	☐ Other:

REFERRING/ORDERING PHYSICIAN OR PATHOLOGIST:	
Doctor Full Name:	NPI #:
Phone Number:	Fax:
Physician Signature (Required): X_____	

REASON FOR CONSULTATION/SPECIFIC DIAGNOSTIC QUESTION(S):

Note: All requests must be accompanied with patient demographics and the original and/or your institution's pathology reports. The primary method for communicating results and billing will be email. The minimum cost for a consultation is $343 but may be higher, with no advance notice, if additional tests are required.