Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

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:

2) INSTITUTION/HOSPITAL SENDING CONSULT:

Contract Person Name: Phone Number:

Name of Institution: Address of Institution:

Contract Email (REQUIRED):

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****

X ______________________________
Physician Signature

6) REASONS FOR THIS SECOND OPINION REQUEST/ DIAGNOSTIC QUESTION FOR OUR PATHOLOGIST: