

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. <u>Include patient information only if patient is being billed</u>)	
☐ 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.