Consultation Request Form

Preferred Pathologist: _____

Department of Pathology, Emory University Hospital
1364 Clifton Road, NE., Suite G180, Atlanta, GA 30322 Phone: (404) 712-5947, Fax: (404)712-4454

Type of Consult –
- ❑ Breast Pathology
- ❑ GI-Hepatic Pathology
- ❑ GYN Pathology
- ❑ Head/Neck Pathology
- ❑ Nephropathology
- ❑ Neuropathology
- ❑ Pulmonary Pathology
- ❑ Soft Tissue Pathology
- ❑ Transplant Pathology
- ❑ Other _____

Facility: _____ Date: _____

Dr. Name: _____ Phone: _____

Address: _____ Email: _____

_____ Fax: _____

_____ NPI: _____

The information in this section is mandatory for patient tracking. Missing information could delay review of the case.

Pt. First Name: _____ Last Name: _____

Age: _____ DOB: _____ Sex: M / F

Materials Submitted:

Slides: Path #: _____ No.: _____ Blocks: Path #: _____ No.: _____

Slides: Path #: _____ No.: _____ Blocks: Path #: _____ No.: _____

Site of Lesion: _____ Collection Date: _____

Party responsible for payment (Please select one):

❑ **Facility (Same as above)**
Contact Person: _____
Email: _____
Phone: _____

❑ **Referring Pathologist**
Contact Person: _____
Email: _____
Phone: _____

❑ **Patient**
We regret we cannot bill Medicaid outside of GA.
Contact Person: _____
Email: _____
Phone: _____

Cases submitted without patient insurance information will be billed to the referring physician/pathologist or alternatively can be charged against a credit card account.

Patient Insurance Information

Insurance Phone: _____

Policy #: _____ Group #: _____

Insurance Company: _____

Address: _____

_____

Use one form per case. Enclose a cover letter outlining the clinical history and a copy of the surgical pathology report, even if incomplete (gross description of specimen), to document patient identify as well as slide labeling.