

## University of Rochester, Strong Memorial Hospital Department of Pathology and Laboratory Medicine

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Please complete information below and send with material to:

Surgical pathology, 601 Elmwood Ave., Box 626, Rochester, NY 14642 Tel: 585-275-3191 opt. 7, Fax: 585-276-1555

Website: https://www.urmc.rochester.edu/pathology-labs/clinical/anatomic-pathology.aspx

## **URMC** Pathology Consultation Request Form

Physician Name:   NPI:   Address:   City/State/Zip:   Fax:   Email:   Email:   Patient Information and History:   Patient Name:   Date of Birth:   Gender:   M   F   I/X   Home Address:   Telephone:   Telephone:   Telephone:   Biopsy Site/Clinical History/Working Diagnosis:   Biopsy Site/Clinical History/Working Diagnosis:   Telephone:   To verify the diagnosis and or grade for treatment purposes   To resolve any equivocal diagnosis for treatment purposes   To resolve a clinical pathological discrepancy for treatment purposes   Clinicopathologic discrepancy   Other   Physician Signature (required):   Physician Signature (required):   Information that may ald in interpretation.   Patient/Insurance   Primary:   Referring Institution/Physician   Patient/Insurance   Primary:   Responsible Party:   Insurance Carrier:   Address:   Address:   Policy # Po	Referring Physicia	an:				
Address:  City/State/Zip: Phone:	•			NPI		
City/State/Zip:						
Phone:Fax:Email:						
Patient Name: Date of Birth: Gender: M F I/X Home Address:						
Home Address:	Patient Informati	on and History:				
Home Address:	Patient Name:		Date	of Birth:	Gender: $\square$ M $\square$ F $\square$ I/X	
City/State/Zip:						
Reason for consultation/specific questions (required):  To verify the diagnosis and or grade for treatment purposes To resolve any equivocal diagnosis for treatment purposes Clinical pathological discrepancy for treatment purposes Clinicopathologic discrepancy Other Physician Signature (required):  Material submitted: Case number(s): # of Slides USS/Blocks Please also include any relevant clinical history, ancillary testing results, laboratory data, imaging, and any other clinical or pathologic information that may aid in interpretation.  Billing Instruction (required): Referring Institution/Physician Patient/Insurance Name: Primary: Responsible Party: Insurance Carrier: Address: Address:	City/State/Zip:		Telephone:			
□ To verify the diagnosis and or grade for treatment purposes   □ To resolve any equivocal diagnosis for treatment purposes   □ To resolve a clinical pathological discrepancy for treatment purposes   □ Clinicopathologic discrepancy   □ Other						
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Name: Primary:  Responsible Party: Insurance Carrier: Address:				☐ Patient/Insurance		
Responsible Party: Insurance Carrier: Address: Address:	-			•		
Address: Address:				-		
Phone: Group # Policy #						
	Phone:				Policy #	

Note: For outside consultation services the patient's insurance information must be provided if the patient is to be billed. If payment is denied by the patient's insurance, you, the referring physician/lab will be responsible for payment for services. Please call our billing department for further information regarding accepted insurances at 585-758-7650. Failure to complete all portions of this form and include necessary documentation will result in delay of processing.