

Consultation Request Form

Sharon W. Weiss, M.D.

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

Facility: _____ Date: _____
Dr. Name: _____ Phone: _____
Address: _____ Email: _____
_____ Fax: _____

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: _____

Send bill for this consult to: (Please check one and provide all the information requested.) Cases submitted without patient insurance information will be billed to the referring physician/pathologist or alternatively can be charged against a credit card account.

Person responsible for processing billing (accounts payable): _____

Billing email address: _____ Billing phone number: _____

Referring pathologist: _____

Clinician (Name, address, phone number): _____

We regret we cannot bill Medicaid outside of GA.

Patient Insurance - Patient (or patient's guardian) Name: _____

Address: _____

Phone: _____ Social Security #: _____

Insurance: _____ (Please provide copy of front/back of insurance card.)

Policy #: _____ Group #: _____

Insurance Company Address: _____

Insurance Company Phone #: _____ Referring Pathologist NPI #: _____

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.