Phoenix Children's

PEDIATRIC PATHOLOGY CONSULTATION REQUEST FORM

Name: _____
MRN: _____
DOB: _____
or Apply Patient Label

PATIENT INFORMATION (Please Print or Place ID Label)				
Last Name	First Name			MI
Date of Birth (DOB)	Sex ☐ Male ☐ Female	SSN	Patient ID #/MRN	
Street Address		City	State	Zip

ORDERING PHYSICIAN INFORMATION (Please Print)			
Physician Name (REQUIRED)	Phone (REQUIRED)		Fax (REQUIRED)
Practice/Facility Name			NPI#
Street Address	City	State	Zip
Physician Email (REQUIRED if sending from outside USA)			
Physician Signature **X**			

BILLING INFORMATION	
☐ Patient Insurance (please attach patient demographics facesheet)	☐ Facility Name: Address: Phone:

ADDITIONAL REPORT **TO** (Please Print)		
Name ☐ Physician ☐ Lab ☐ Other	Phone	Fax

Diagnosis / ICD-10
Diagnosis / ICD-10
Other Clinical Information / Special Instructions

MATERIAL SUBMITTED (for internal use only)			
Slides Case #: _____ Case #: _____ Case #: _____	# of slides: _____ # of slides: _____ # of slides: _____	Fresh frozen tissue □: _____ Gross photographs □ # of photographs _____ Electron micrographs □ # of EM's _____	
Blocks Case #:_____ Case #:_____	# of blocks: _____ # of blocks: _____	EM blocks □ EM# _____ Other _____	# of EM blocks _____
CD Images # of images _____			
Other			

Please enclose a copy of the Pathology Report (even if report is preliminary).

For billing questions, please contact the Anatomic Pathology Department, (602) 933-1283.

Please return form to Anatomic Pathology Department - (P) 602-933-1283 (F) 602-933-1284