Weill Cornell Medical College

BREAST PATHOLOGY CONSULTATION REQUEST

NEW YORK PRESBYTERIAN HOSPITAL – WEILL CORNELL MEDICAL COLLEGE
DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE
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From: _____ Date: _____

Address: _____ Phone: _____

_____ Fax: _____

_____

Patient Name: _____ Age: _____ DOB: _____ Sex: M ☐ F ☐

Home Address: _____ City: _____ State: _____ Zip: _____

Site of Lesion: _____

Reason for Consultation: _____

Materials Submitted: Please limit to 20 H & E slides (unlimited immunostains)

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

Path #: _____ No.: _____ Path #: _____ No.: _____

Billing Instructions: (MUST CHECK ONE)

This Pathology material is being sent at the request of the:

☐ Our Pathologist for an Expert Consultation (Please send your bill for services to the address below):

_____

_____

_____

☐ The Patient's Referring Clinician for a Second Opinion
(See attached patient billing information)

☐ Patient asked for Second Opinion (See attached patient billing information)

Referring Pathologist NPI#:_____