

**PATHOLOGY CONSULTATION REQUEST**

**Patient Demographics**

**Failure to provide all requested information may delay patient care.**

**Please include this completed form with the requested materials.**

**SECTION 1**

DATE: \_\_\_\_\_

TO: Vanderbilt University Medical Center  
ATTN: PATHOLOGY CONSULT SERVICE  
1211 Medical Center Drive: 3020A-VUH  
Nashville, TN 37232  
Phone: 615.322.0967 Fax: 615.322.1303

FROM: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**SECTION 2**

**Will this patient receive care at Vanderbilt?**  No  Yes if known, appt. date at Vanderbilt: \_\_\_\_\_

**PATIENT LEGAL NAME:** \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Patient D.O.B. (mo/day/year): \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: \_\_\_\_\_

Patient phone: \_\_\_\_\_ Race: \_\_\_\_\_

**CONSULT REQUESTED BY (choose one):**

Vanderbilt Physician  non-Vanderbilt Physician  Patient  Other: \_\_\_\_\_

**Ordering Physician Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

PLEASE PRINT

Is the ordering physician a pathologist?  No  Yes

**Tissue/Material**  Surgical Pathology  Cytology

Please provide patient clinical history/diagnosis and any specific diagnostic questions or requests :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION 3**

**MATERIAL SUBMITTED:**

***Please provide 10 unstained slides OR a block of representative tissue for ancillary studies***

**Slides** Case # \_\_\_\_\_ # of slides: \_\_\_\_\_  
Case # \_\_\_\_\_ # of slides: \_\_\_\_\_  
Case # \_\_\_\_\_ # of slides: \_\_\_\_\_

Fresh frozen tissue  
 Gross photographs # of photographs \_\_\_\_\_  
 Electron micrographs # of EM's \_\_\_\_\_

**Blocks** Case # \_\_\_\_\_ # of blocks: \_\_\_\_\_  
Case # \_\_\_\_\_ # of blocks: \_\_\_\_\_

EM blocks EM# \_\_\_\_\_ # of EM blocks \_\_\_\_\_  
 Other \_\_\_\_\_

**CD Images** # of images \_\_\_\_\_  **Other** \_\_\_\_\_

*Note: All recut and unstained slides will be retained by Vanderbilt.*

# Instructions to Complete Pathology Consultation Request

Failure to provide all requested information may delay patient care.

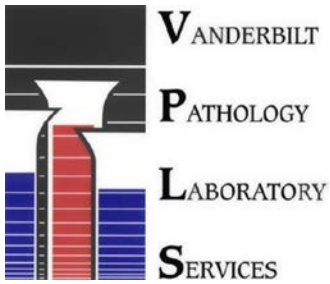
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## PATIENT DEMOGRAPHICS

1. It is the responsibility of the requesting physician, facility, or patient to ensure that all materials for the requested service are provided.
  - a. Copies of pathology/cytology reports for each case.
  - b. Slides corresponding to pathology/cytology reports.
  - c. A minimum of one block OR 10 unstained slides with representative tumor tissue
2. For all consult requests from Vanderbilt physicians:
  - a. Vanderbilt staff is responsible for completing Sections 1 & 2 and sending the request to the referring site.
  - b. Referring facility must complete Section 3.
3. For all consult requests from non-Vanderbilt physicians, facilities or patients, please complete Sections 1, 2 and 3.
4. In Section 2, **all consult requests from physicians (Vanderbilt or non-Vanderbilt physicians) MUST include the ordering provider's legibly printed full name.**

## DOMESTIC PATIENT BILLING INFORMATION

5. Section 1 **MUST** be completed by the ordering physician (either Vanderbilt or non-Vanderbilt) or requesting site.
6. Section 2 should be completed by the referring site for all consults requested by a non-Vanderbilt physician or by the patient. A computer generated report may be attached if it contains all necessary and current patient insurance information; photocopies of insurance cards may be included as well.
7. When a Vanderbilt physician has ordered the consult, Section 3 (when applicable, Section 4) must be completed by the office staff or current insurance demographic printout from EPIC may be attached; photocopies of insurance cards may be included as well.



**PATHOLOGY CONSULTATION**

**Domestic Patient Billing Information**

*Note: patient and/or insurance provider will be contacted. We are unable to process out of state Medicaid requests  
Incomplete patient or billing information will delay processing of your request.*

**Section 1**

**FIELDS DENOTED WITH ASTERISK MUST BE COMPLETED FOR ALL REQUESTS REGARDLESS OF PAYER**

\*Patient Name \_\_\_\_\_

\*Diagnosis: \_\_\_\_\_ \*ICD-9 Code: \_\_\_\_\_

\*Clinical Information: \_\_\_\_\_  
\_\_\_\_\_

**Section 2 Private Payer**

Name:		
Mailing Address:		
City/State:	Country	Zip Code:
Phone:	Fax:	E-mail

Send the bill to the attention of: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

**Section 3 Bill patient's primary insurance. Medicare patients, please list secondary insurance if applicable**

*Any insurance updates must be received within 40 days of date of service to re-bill the account*

<b>Health Plan:</b>		Phone:
Address:		<b>Name of Subscriber:</b>
Address:		
<b>DOB of Subscriber</b>		<b>Relationship to Patient</b>
Policy Number	Group Number:	Effective Date:
Referring Physician UPIN/NPI:		Fax:

**Section 4 Bill patient's secondary insurance.**

<b>Health Plan:</b>		Phone:
Address:		
Address of <b>Subscriber:</b>		
<b>DOB of Subscriber</b>		<b>Relationship to Patient</b>
Policy Number:	Group Number:	Effective Date:
Referring Physician UPIN/NPI:		Fax: