VANDERBILT UNIVERSITY MEDICAL CENTER

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

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

DATE: _________
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:

☐ **Slides** Case # ___________ # of slides: _______ ☐ Fresh frozen tissue
Case # ___________ # of slides: _______ ☐ Gross photographs # of photographs ________
Case # ___________ # of slides: _______ ☐ Electron micrographs # of EM's______

☐ **Blocks** Case # ___________ # of blocks: ______ ☐ EM blocks EM#____ # of EM blocks _____
Case # ___________ # of 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.

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 for with representative tumor tissue for molecular studies
    d. A minimum of 10 unstained slides containing 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

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

Section 4 Bill patient's secondary insurance.

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