UNIVERSITY OF PITTSBURGH ORAL & MAXILLOFACIAL BIOPSY SERVICE

REQUEST FOR PATHOLOGY CONSULTATION (PLEASE TYPE OR PRINT)

Patient Information – Complete All Fields

Last Name	First Name	M.I.	Social Security Number
Street Address	City	State	Zip Code
Bill Submitting Institution ☐ Bill Patient* ☐ *Note: Insurance information must be supplied if patient is to be billed. If payment is denied by the patient's insurance, you will be responsible for payment for services.		Birth Date	Sex / Phone
Insurance Carrier	Policy #	Group #	Name and relationship of Policy Holder
Insurance Carrier Address	City	State	Zip Code

Collection/Reporting Information – Complete all Fields

Requesting Clinician Last Name	First Name
Clinician Phone# (Including Area Code)	Fax Number (Inc. Area Code)

Institution Name & Address	Street	City	State	Zip Code

Date Specimen Collected	Institution Phone # (Inc. Area Code)	Fax Number (Inc. Area Code)
Copy to: Physician Name	Phone # (Inc. Area Code)	Fax Number (Inc. Area Code)

Clinical History:_____

_____

Pre-op Diagnosis _____ Post-op Diagnosis _____ Procedure _____

Specimen(s): Outside case #(s) _____

Prepare slides (#)*: _____ Unstained slides(#)**_____Adhesive used:_____
**Recut slides preferred to allow for retention by UPMC Faculty* ***Blocks are preferred.*
Blocks(#) & Description:_____ Fixative:_____

Pathology Consultation Request: Must check one for testing to occur. Attach original pathology report from your institution!

☐ Complete formal consultation: Designated Pathologist (optional): _____
☐ Special stains and interpretation (state individual stains): _____
☐ Other, specify: _____