Weill Cornell Medicine
Dermatopathology

DERMATOPATHOLOGY CONSULTATION FORM

Please complete all information below and send with materials to:
Dermatopathology 1300 York Avenue, F-310 New York, NY 10065
Tel:212-746-6434 Fax:212-746-8570

Date _____

REFERRING INSTITUTION / CLINICIAN

Institution/Clinician Name _____ NPI#_____

Address _____ City/State/Zip _____

Phone _____ Fax _____ Email _____

Additional physicians to get report:

_____

_____

PATIENT INFORMATION AND HISTORY

Patient Name _____ Date of birth _____ Gender ☐ Male ☐ Female

Home Address _____ City/State/Zip _____ Telephone _____

Clinical History _____

_____

Reason for consultation / specific questions (***required***)

- ☐ To verify the diagnosis and or grade for treatment purposes
- ☐ To resolve an equivocal diagnosis for treatment purposes
- ☐ To resolve a clinical-pathological discrepancy for treatment purposes

Working Diagnosis:

_____

_____

Physician's Signature _____ Date _____

MATERIALS SUBMITTED

Slides- Path#: _____ # of Slides: _____ Blocks- Path #: _____ # of Blocks: _____

Slides- Path#: _____ # of Slides: _____ Blocks- Path #: _____ # of Blocks: _____

BILLING INSTRUCTION: You must select one

☐ **Referring Institution/Clinician** *(See Above)*

***Note: For outside consultation services the patient's insurance information must be supplied if the patient is to be billed. If payment is denied by the patient's insurance, you will be responsible for payment for services. Please visit the Cornell Pathology website to verify the accepted insurance list.**
http://cornellpathology.com/sites/default/files/Insurance-Participation-Listing.pdf

☐ **Patient**

(***Primary)***
Insurance Carrier _____
Address _____
Group # _____ Policy # _____

(***Secondary)***
Insurance Carrier _____
Address _____
Group # _____ Policy # _____

(REQUEST CANNOT BE PROCESSED WITHOUT ORIGINAL PATHOLOGY REPORT AND COMPLETED REGISTRATION INFORMATION)

Rev 5/16