THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER

PATHOLOGY CONSULTATION REQUEST

Dear Contributing Physician:

To better serve you and your patients, for whom pathology interpretations are being requested, U.T.M. D. Anderson Cancer Center requires the following information and materials to be submitte d, preferably by overnight mail.

Please use one form per case and accompany with (1) covering letter containing a summary of the clinical history, operative findings and source of material and (2) a copy of the surgical pathology report, even if incomplete. A WRITTEN REPLY WILL BE SENT TO THE CONSULTING PHYSICIAN'S ADDRESS IN EACH CASE.

TO:	From: Date:
OUTSIDE SLIDE CONSULTATION Department of Pathology, Box 85 The University of Texas M.D. Anderson Cancer Center 1515 Holcombe Blvd. Houston, Texas 77030 **Phone:** (713) 792-3111 **Fax:** (713) 745-2745	Physician: Office address: Phone: Fax:

Patient's complete name: _____

Date of Birth: _____ Month/Day/Year

SSN: _____

Marital status: _____ Sex: _____ Race: _____

Patient's mailing address:

_____

_____

_____

_____

MATERIALS SUBMITTED:

☐ Slides: Path # _____ How many? _____
Path # _____ How many? _____
☐ Blocks: Path # _____ How many? _____
Path # _____ How many? _____

☐ Wet fixed tissue
☐ Electron micrographs
☐ EM Blocks EM # _____
☐ X-rays How many? _____

☐ Glutaraldehyde How many? _____
How many? _____

Which material needs to be returned to you? _____

BILLING INFORMATION:

If you want us to bill your patient directly for these services, please provide complete patient data requested above and check off "Bill Patient" below. Be sure that the patient is aware that his/her material has been sent to U. T. M. D. Anderson and that he/she will receive a statement from Patient's Billing Service (PBS) requesting payment. However, if you or another physician or institution is to be responsible for payment to PBS, please complete the patient data above and the responsible party information below.

CHECK ONE BELOW:

☐ Bill my patient
☐ Send bill to the responsible party and address listed below.

Name of patient, physician or institution to be billed: _____

Patient's mailing address: _____

Complete billing address: _____

Responsible party's phone number: _____

Referring physician's unique physician's provider number (UPIN) and name: _____

Any special identification to be indicated on the statement i.e., Purchase Order Number: _____