DERMATOPATHOLOGY
NORTHWEST

For lab use only

SLIDE CONSULTATION REQUEST FORM

Requesting Clinician Name:	Phone Number:	Fax Number:
CC: (Name, Phone and Address)		

Patient Information:

Patient Last Name:	First Name:	M.I.	D.O.B.	SEX ☐ Male ☐ Female

Billing Information:

BILL TO: ☐ Physician ☐ Patient* ☐ Insurance*

***The following information must be included:**

**The patient demographic sheet*
** Both sides of the patient insurance card(s)*
** Secondary insurance information (if applicable)*

Materials Submitted:

CASE NUMBER: _____

☐ Slides #of slides _____
☐ Blocks #of blocks _____
☐ Photos
☐ Clinical Notes
☐ Other _____

☐ **PATHOLOGY REPORT**
All consultation requests must be submitted with a pathology report

Clinical Information:

Date of Specimen Collection: _____
Site of Lesion: _____

Clinical History:

2330 130th Avenue NE #201, Bellevue, WA 98005 Phone: (425) 455-9945 (877) 210-8133 Fax: (425) 455-9947