

DEPARTMENT OF PATHOLOGY CONSULT REQUISITION

1600 Divisadero Street, Room R200
San Francisco, CA 94115
Phone: (415) 353-1613 Fax: (415) 353-7276
Email: pathology-consult-services@ucsf.edu

MRN:
PT. NAME:
BIRTHDATE: GENDER:
CLINIC:
VISIT #:

All REQUIRED fields and documents MUST be submitted to avoid any delay in test results. A copy of the Pathology Report or preliminary with gross description is **REQUIRED.**

Requesting Facility/Clinic (REQUIRED)

Ordering/Referring Provider: _____ Phone: _____ Fax: _____
Address: _____

Sender's Name: _____ Phone: _____

Bill To (REQUIRED) (Check One Only):

Patient SELF PAY (Pay out of pocket) Referring Facility PPO HMO (**REQUIRED for CPT codes: 88321, 88323, 88312, 88313, 88341, 88342, 88360. Please include authorization letter**)

Medicare - For consult within 14 days of surgery, **Medicare requires consultants to bill the referring facility for technical charges.**
Please indicate below which facility is responsible:

Facility Name: _____

Date of Surgery: _____

ICD-10 code(s) is/are necessary to indicate medical necessity and for billing purposes. If payment is denied by insurance, referring facility is required to obtain a signed Advance Beneficiary Notice (ABN) which acknowledges patient responsibility for payment.

ICD-10 CODE (REQUIRED)	RELEVANT CLINICAL HISTORY / CONSULT QUESTION:

Consult Slides/Blocks (REQUIRED) (Providing blocks and/or unstained slides may expedite a final report):

Specimen #: _____	Specimen #: _____	Specimen #: _____
<input type="checkbox"/> Stained Slide Count _____	<input type="checkbox"/> Stained Slide Count _____	<input type="checkbox"/> Stained Slide Count _____
<input type="checkbox"/> Paraffin Block Count _____	<input type="checkbox"/> Paraffin Block Count _____	<input type="checkbox"/> Paraffin Block Count _____
<input type="checkbox"/> Unstained Slide Count _____	<input type="checkbox"/> Unstained Slide Count _____	<input type="checkbox"/> Unstained Slide Count _____

Special Instructions/Comments: