JOHNS HOPKINS
MEDICINE
PATHOLOGY

JHML PATHOLOGY CONSULTATION
Please complete the information below and print this form.

☐ Consult requested by pathologist
☐ Consult requested by outside clinician
☐ Consult requested by JHH clinician (confirming)

Physician Name _____ NPI# _____

Address _____

City _____ State ____ Country _____ Zip _____

Phone_____Fax _____ Email _____

Other doctors to get a copy of the report:

Physician name _____

Address_____

City_____ State_____ Zip_____

****

Patient's Name _____Date of birth_____

Patient's 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.
Other

Working diagnosis

Requesting Physician signature_____ Date _____

MATERIAL SUBMITTED: specify case numbers

Total number of slides Case number/s _____

Total number of blocks: Case number/s _____

Other material: _____

Which material needs to be returned to you? all ☐ none ☐

Recuts (may be retained by JHML)? yes ☐ no ☐

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Billing Information

Note: *patient and/or insurance provider may be contacted.*

We do not accept Medicaid from states other than Maryland.

The cost of a second opinion from Johns Hopkins may be covered by your insurance. If you have an HMO *or* preferred provider organization (PPO) coverage, you will need an authorization to have a second opinion done by Johns Hopkins University Reference Laboratories.

Please select one:

- ☐ Bill patient's home address as above *(patient may be contacted)*
- ☐ Bill patient's primary insurance.
- ☐ Bill Medicare (Medicare patients, please list secondary insurance.)

Patient's Name: _____

Address: _____

Address: _____

City: _____ State ___ Zip _____

Phone: _____

SSN: _____

Date of Birth: _____

Gender: ☐ M ☐ F

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Billing Information (continued)

Name of Insured: _____

(if address of insured is different than the patient's address, please provide here)

Insured Address: _____

Insured Address: _____

Insured City: _____ State ____ Country _____Zip _____

Primary Insurance

Insurance Company Name _____

Insurance Company Phone _____ Insurance Company Fax _____

Group Number _____

Policy Number _____

Effective Date _____

Insurance Company Address _____

Insurance Company Address _____

Insurance City _____ State ____ Country _____ Zip _____

Secondary Insurance

Insurance Company Name _____

Insurance Company Phone _____ Insurance Company Fax _____

Group Number _____

Policy Number _____

Effective Date _____

Insurance Address _____

Insurance Address _____

Insurance City _____ State ____ Country _____ Zip _____