JOHNS HOPKINS
MEDICINE
PATHOLOGY

JHML PATHOLOGY CONSULTATION: Request From Physician

To have charges billed to insurance this form must be completed by your physician.

Consult requested by Clinician

Physician Name _____ NPI# _____

Address _____

Address _____

City _____ State ____ Country _____ Zip _____

Phone_____Fax _____ Email _____

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