DATE RECEIVED	**Wake Forest Baptist Health** *Diagnostic Laboratories* ***Consult Request Form***	Anatomic Pathology Medical Center Boulevard Winston-Salem, NC 27157 Client Services: 877-933-9522 Fax: 336-716-8866	CLIENT LOCATION: Address 1: Address 2: Phone # Fax #

PLEASE FILL IN COMPLETELY AND/ OR ATTACH ALL REQUIRED INFORMATION -- PLEASE PRINT (* Denotes Required Field)

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; (2) a copy of the surgical pathology report, even if incomplete.

Office ID:	Call Results to with area code:	Fax Results to with area code:	Bill Type: ___Insurance ___Patient ___Client

*** Patient Name:**	Patient Address:	Race:	Sex: M | F | U	D.O.B: / /

***Consult Request By:** ___ **Pathologist** ___ **Clinician** ___ **Other:** _____	*** Ordering Physician Name:**	Guarantor Name & Address:		
	Ordering Physician NPI:	Insurance Name & Code (attach copy):	Subscriber Name:	Relationship:
		Group Name:	Policy ID:	Group ID:

Specimen Information

Patient Clinical History:

Reason for Consultation:

Specific questions:

Working or differential diagnosis:

MATERIAL SUBMITTED

☐ SLIDES	Path #	# of Slides:	☐ Wet Fixed tissue	☐ Fresh frozen tissue
	Path #	# of Slides:	☐ Gross photographs	# of photographs_____
	Path #	# of Slides:	☐ Electron micrographs	# of EM's_____
☐ BLOCKS	Path #	# of Blocks:	☐ EM blocks EM#	# of EM blocks_____
	Path #	# of Blocks:	☐ Other	
☐ IMMUNOFLUORESCENCE STUDY ONLY				
☐ OTHER				

What material can be retained by us?
What material needs to be returned to you?

Is the patient a beneficiary of Medicare/ Medicaid or any other government-sponsored insurance plan? (check one) ☐ YES ☐ NO

If Yes, was the patient registered as a hospital inpatient or outpatient at the time the specimen was taken? (check one) ☐ YES ☐ NO

If the answer to both questions is "yes" any technical charges will be billed to the r ferring hospital.