



Boston Children's Hospital

Where the world comes for answers

PATHOLOGY CONSULT REQUISITION

BCH
PATHOLOGY
LABEL

DEPARTMENT OF PATHOLOGY – Farley 190 - BCH3027
300 LONGWOOD AVENUE, BOSTON, MA 02115 | PHONE: 617-355-7431 | FAX: 617-730-0207
EMAIL: pathology@childrens.harvard.edu

Service Requested: Anatomic Pathology Consultation Molecular Consultation

PATIENT INFORMATION: (PLEASE PRINT IN BLACK INK)

LAST NAME		FIRST	MI
ADDRESS		CITY	STATE ZIP
BIRTH DATE	SEX	PHONE	PATIENT ID #

REQUESTOR:	ORDERING PHYSICIAN CONTACT INFORMATION:	
NAME	PHYSICIAN NAME	
ADDRESS	PHYSICIAN NPI (NON-BCH PROVIDERS)	PHYSICIAN PHONE
	PHYSICIAN EMAIL	
PHONE	<input type="checkbox"/> Fax report to: () _____	
	<input type="checkbox"/> Email report to: _____	
REQUESTOR SIGNATURE	Is this order for a clinical research study or trial (<i>select one</i>): <input type="checkbox"/> Yes or <input type="checkbox"/> No If YES, provide study name: _____	

BILL TO: Patient Insurance Requestor Patient Self-Pay *HMO Insurance Authorization #* _____

Charges for patients classified as a hospital "inpatient or "outpatient" at the requesting facility on the date of service must be billed to the requesting facility unless an appropriate exception applies. SSA §1833(h)(5)(A); SSA §1833(h)(5)(A)(iii); SSA §1861(w)(1); 42 §CFR 414.510

SUBSCRIBER LAST NAME	FIRST	MI	INSURANCE PHONE	INSURANCE NAME
CLAIMS ADDRESS (IF AVAILABLE)				BENEFICIARY/MEMBER #
CITY			STATE	ZIP
				GROUP # (IF AVAILABLE)

FOR INSTITUTIONAL USE ONLY

PATIENT STATUS: Inpatient Outpatient Non-Hospital Patient Hospital Discharge Date: ____/____/____

With the exception of patient-initiated consults, you may be required to obtain a prior insurance authorization. Denied claims for any reason will be billed to the requestor.

ICD-10 Diagnosis Code Required: 1. _____ 2. _____ 3. _____

CLINICAL INFORMATION: See Attached Letter Copy of Pathology Report
A COPY OF THE PATHOLOGY REPORT IS REQUIRED. A SEPARATE PATHOLOGIST LETTER IS OPTIONAL.

BRIEF CLINICAL HISTORY

SPECIMEN INFORMATION (ANATOMIC & MOLECULAR):

Collection Date: ____/____/____ Time: _____

BODY SITE	CLIENT CASE NUMBER(S)
-----------	-----------------------

Blocks Qty: _____ Stained Slides Qty: _____ Unstained Slides Qty: _____ Other Qty: _____

MOLECULAR TEST MENU (PLEASE SELECT AT LEAST ONE)*. Boston Children's Hospital, Department of Pathology, ATTN: LAMPP Lab, SK0462, 300 Longwood Avenue, Boston, MA 02115

Solid and brain tumor fusion panel Heme malignancy fusion panel geneVa Panel BRAF V600E ddPCR

PIK3CA ddPCR (*select variants*): C420R E542K E545K H1047L H1047R All MYOD1 L122R ddPCR

Nucleic acid extraction only (*specify type*): DNA RNA TNA

Sample Origin: Bone marrow Blood Tissue (Type: _____)

Sample Prep: Fresh Frozen Air dried Paraffin (Fixative: Formalin Other: _____)

Estimate of % tumor cellularity: _____ *Note: Acid decalcification and Bouin's fixative are not acceptable*

***Procedures include Professional Interpretation unless otherwise requested.** No Professional Interpretation

For Department Use Only:

DATE RECEIVED	ACCESSION #	RECEIVED BY
---------------	-------------	-------------

ADDITIONAL INFORMATION