

## **PATHOLOGY CONSULT** REQUISITION

BCH PATHOLOGY LABEL

## Where the world comes for answers

**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 IN LAST NAME			FIRST		MI			
ADDRESS			CITY	STATE	Z	IP		
BIRTH DATE	SEX	PHONE		PATIENT ID #				
REQUESTOR: ORDERING PHYSICIAN CONTACT INFORMATION:								
NAME			PHYSICIAN NAME					
		PHYSICIAN NPI (NON-BCH PROVIDERS) PHYSICIAN PHONE						
ADDRESS		PHYSICIAN EMAIL						
		☐ Fax report to: ( )						
		☐ Email report to:						
BUONE		Is this order for a clinical research study or trial (select one):   Yes or  No						
PHONE		If YES, provide study name:						
REQUESTOR SIGNATURE								
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								
requesting facility unless SUBSCRIBER LAST NAME		on applies. SSA §18 FIRST	333(h)(5)(A); SSA §1833(h)(5)(A	A)(iii); SSA §1861(w)(1) INSURANCE PHON			ARY/MEMBER#	
CLAIMS ADDRESS (IF AVAILABLE) CITY		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								
CLINICAL INFORMATION: ☐ See Attached Letter ☐ Copy of Pathology Report								
A COPY OF THE PATHOLOGY REPORT IS REQUIRED. A SEPĂRATE PATHOLOGIST LETTER IS OPTIONAL. BRIEF CLINICAL HISTORY								
SPECIMEN INFORMATION (ANATOMIC & MOLECULAR):								
Collection Date: / / Time:								
BODY SITE		·	CLIENT CASE NUMBER(S)					
				N. 1 O.		011 0		
			Unstained S					
MOLECULAR TEST MENU (PLEASE SELECT AT LEAST ONE)*: Boston Children's Hospital, Department of Pathology, ATTN: LAMPP Lab, Bader 013, 300 Longwood Avenue, Boston, MA 02115								
☐ Solid and brain tumor fusion panel ☐ Heme malignancy fusion 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:   □ 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 Us	e Only:	ACCESSION#		RECEIVED BY				
		ACCESSION#		NECEIVED BY				
ADDITIONAL INFORMATION	DN							