Weill Cornell Medicine
Dermatopathology

WCM DERMATOPATHOLOGY CONSULTATION

Please complete the information below, print and send with blocks, slides and original Pathology report to:
Dermatopathology, 1300 York Avenue F-310 New York, NY 10065 Tel:212-746-6434 Fax: 212-746-8570

Date _____

REFERRING PHYSICIAN

Physician Name _____ NPI#_____

Address _____ City/State/Zip _____

Phone _____ Fax _____ Email _____

PATIENT INFORMATION AND HISTORY

Patient Name _____ Date of Birth _____ Sex ☐ Male ☐ Female

Address _____ City/State/Zip _____ Phone _____

Clinical History _____

_____

Site of Biopsy(s) _____

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

Working Diagnosis:

_____

_____

Physician's Signature _____ Date _____

MATERIALS SUBMITTED

Slides- Path#: _____ # of Slides: _____ Blocks- Path #: _____ # of Blocks: _____

Slides- Path#: _____ # of Slides: _____ Blocks- Path #: _____ # of Blocks: _____

BILLING INSTRUCTION: You must select one

☐ **Referring Clinician/Institution**

Name _____

Responsible Party _____

Business Address _____

City /State/Zip _____

Business Phone _____ Email _____

☐ **Patient/Insurance**

Insurance Carrier _____

Address _____

Group # _____ Policy # _____

Secondary

Insurance Carrier _____

Address _____

Group # _____ Policy # _____