



Ship Specimens to:
 Wisconsin Diagnostic Laboratories
 ATTN: PASS Rm L29
 8777 W. Connell Avenue
 Milwaukee, WI 53226
 Client Services: (414) 805-7600
 wisconsinidiagnostic.com

PATHOLOGY CONSULTATION REQUEST FORM

PATIENT INFORMATION

Patient's Name DOB (mm/dd/yyyy) Sex

Clinical Information / Reason for Consultation (can be provided separately)

- See Attached Letter Copy of Pathology Report (REQUIRED)

SUBMITTING PROVIDER INFORMATION

Practice / Institution Name Client Number
 Ordering Physician NPI
 Address Phone Number
 Email Fax Number

BILLING INFORMATION

Bill To: Client / Institution Same Address as Above (if billing address is different, write in below)
 Billing Address Phone Number
 Email Fax Number

PATHOLOGY CONSULTATION REQUEST

Pathologist Requested

Please check below for a Preferred Subspecialty Group.

In addition to what has been ordered, the MCW Pathologist is authorized to add other testing as needed to assist in evaluation.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Brain Autopsy | <input type="checkbox"/> Dermatopathology | <input type="checkbox"/> Gynecologic | <input type="checkbox"/> Neuropathology |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Head & Neck/Oral | <input type="checkbox"/> Pulmonary |
| <input type="checkbox"/> Cardiothoracic | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Hepatic | <input type="checkbox"/> Renal Pathology |
| <input type="checkbox"/> Cytopathology | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Hematopathology | |
| <input type="checkbox"/> Special Stain(s): <input type="text"/> | <input type="checkbox"/> Immunohistochemistry: <input type="text"/> | | |

MATERIALS SUBMITTED / SPECIMEN INFORMATION

I acknowledge that WDL/MCW will become the custodian of all material submitted with this consultation request for 14 days post sign out. Materials will be returned by standard US Mail, unless a FedEx or UPS account number is provided.

Body Site Accession # Specimen ID #
 Slides # Unstained # Stained Number of Blocks
 Collection Date Other

For cases requiring molecular or FISH testing, the contributor's approval is required. By signing this form, I attest that the test requested above is medically necessary and has been appropriately documented in the patient's medical record. I agree to all consultation fees and any costs associated with completing this consultation. An itemized invoice will be sent monthly with payment terms of net 30 days.

Ordering Provider's Signature

Date

Time

WDL CLIA#: 52D0391886
 MCW DERM / EM CLIA#: 52D0720169