Boston Children's Hospital
Until every child is well™

Department of Pathology
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PATHOLOGY CONSULTATION REQUISITION

PATIENT INFORMATION *(all fields are mandatory)*			**REQUESTING CLINICIAN** *(receives consultation report)*		
Name:			**Clinician Name:**		
Address:			**Institution/Hospital:**		
Address:			**Address:**		
City:	**State:**	**Zip:**	**Address:**		
Phone:	**MRN:**		**City:**	**State:**	**Zip:**
Gender: M F	**Date of Birth:**		**Phone:**	**Fax:**	
SUBSCRIBER *(insurance policy holder)* **INFORMATION**			**GUARANTOR** *(person responsible for the bill)*		
Primary Insurance Carrier:			**Name:**		
Policy #:			**Address:**		
Subscriber Name:			**Address:**		
Subscriber DOB:			**City:**	**State:**	**Zip:**
Insurance Address:			**Phone:**		
City:	**State:**	**Zip:**	**Relationship to Patient:**	**DOB:**	
Insurance Phone:			**Is Guarantor the Legal Guardian?:**	**Y**	**N**

For consultations requested by the family or treating clinician, the patient and/or their insurance provider is liable for billing.
For consultations requested by a pathologist, the requesting pathologist's institution is liable for billing.

CLINICAL INFORMATION
Clinical Diagnosis:
Clinical History:
ICD-10 (if available):

FOR DEPARTMENT USE ONLY		
Date Received:	**Accession Number:**	**Received By:**

Additional Information: _____