Weill Cornell Medicine Dermatopathology

Cynthia M. Magro, MD, Director
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
E-mail: cornelldermpath@med.cornell.edu Website: www.dermpath.weill.cornell.edu

WCM Dermatopathology Consultation

Date:

Referring Physician

Physician Name: NPI#:
Address:
City/State/Zip:
Phone: Fax: Email:

Patient Information and History

Patient Name: Date of Birth: Gender: ☐ Male ☐ Female
Home 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

PHYSICIAN SIGNATURE *(required)*:
Date:

Working Diagnosis:

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 Institution/Physician

Name:
Responsible Party:
Business Address:
City /State/Zip:
Business Phone:
Email:

☐ Patient/Insurance

Primary
Insurance Carrier:
Address:
Group # Policy #

Secondary
Insurance Carrier:
Address:
Group # Policy #

***NOTE:** For outside consultation services the patient's insurance information must be supplied if the patient is to be billed. If payment is denied by the patient's insurance, you "referring physician" will be responsible for payment for services. Please visit the Cornell Pathology website to verify the accepted insurance list. https://pathology.weill.cornell.edu/sites/default/files/insurance-participation-listing.pdf

PRINT RESET

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