



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 Room. F-310 New York, NY 10065 Tel: 212-746-6434 Fax: 212-746-8570

AT LEAST 10 UNSTAINED SLIDES OR THE PARRAFIN BLOCK MUST BE INCLUDED FOR ADDITIONAL TESTING. WITHOUT THE NECESSARY ADDITIONAL MATERIAL, THE CASE WILL BE RETURNED.

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 # _____