THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER
Making Cancer History™

HEMATOPATHOLOGY CONSULTATION REQUEST

Dear Contributing Physician:

To better serve you and your patients, for whom pathology interpretations are being requested, U.T.M. D. Anderson Cancer Center requires the following information and materials to be submitted, preferably by overnight mail.

Please use one form per case and accompany with (1) covering letter containing a summary of the clinical history, operative findings and source of material and (2) a copy of the surgical pathology report, even if incomplete. A WRITTEN REPLY WILL BE SENT TO THE CONSULTING PHYSICIAN'S ADDRESS IN EACH CASE.

TO: OUTSIDE SLIDE CONSULTATION Department of Hematopathology, Box 72 The University of Texas M.D. Anderson Cancer Center 1515 Holcombe Blvd. Houston, Texas 77030 **Phone:** (713) 794-1094 or 800-315-8424 **Fax:** (713) 745-1994	**FROM:** _____ **DATE:** _____ **Physician:** _____ **Office address:** _____ _____ _____ _____ **Phone:** _____ **Fax:** _____

Patient's complete name: _____

Date of Birth: _____ Month/Day/Year

SSN: _____

Marital status: _____ Sex: _____ Race: _____

Patient's mailing address:
_____
_____
_____
_____

Patient's Telephone Number: _____

MATERIALS SUBMITTED:

☐ Slides: Path # _____ How many? _____
Path # _____ How many? _____
☐ Blocks: Path # _____ How many? _____
Path # _____ How many? _____

Which material needs to be returned to you?

BILLING INFORMATION: Fee payment arrangements must be made prior to the review.
If you want us to bill your patient for these services, please provide complete patient data requested above and insurance info. If you or another physician or institution is to be responsible for payment to PBS, please complete the patient data above and the responsible party information below.

CHECK ONE BELOW:

☐ Bill patient's insurance (attach Demographic Sheet)
☐ Send bill to the responsible party and address listed below.

Name of patient, physician, or institution to be billed: _____

Billing address 1: _____

Billing address 2 : _____

Responsible party's phone number: _____

Referring physician's name and NPI number (required): _____

Any special identification to be indicated on the statement i.e., Purchase Order Number: _____
Please remember that our service is for pathology second opinions only. We cannot discuss or recommend treatment options.

Disclosure of your social security number (SSN) is requested from you in order for The University of Texas M.D. Anderson Cancer Center to process your request for diagnostic services. No statute or other authority requires that you disclose your SSN for this purpose and we may not deny services if you choose not to disclose it. Failure to provide your SSN, however, may result in the creation of a duplicate patient number being issued, which may lead to multiple medical records. Further disclosure of your SSN is governed by the Texas Public Information Act and other applicable law.

For questions related to the above information call at (800) 315-8424 or Fax (713) 745-1994.