

Washington University Dermatopathology Center

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CONSULT REQUEST

DATE

LAB USE ONLY

Accession Number

Date Received:
Accessioner:

ORDERING PROVIDER - PLEASE SIGN AT THE BOTTOM

Name:	Institution:
Address:	
Phone:	Fax:
Copy to Provider/Institution A:	Fax:
Copy to Provider/Institution B:	Fax:

PATIENT INFORMATION - PLEASE ATTACH COPY OF INSURANCE CARD/DEMOGRAPHIC SHEET

Last Name:	First Name:	Middle Name:
DOB:	Race:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F

OUTSIDE ACCESSION#	Number of SLIDES	BLOCKS	ANATOMICAL SITE	CLINICAL DESCRIPTION
A)				
B)				
C)				
D)				

LAB USE ONLY
PATHOLOGICAL DIAGNOSIS

ORDERING PROVIDER'S SIGNATURE: X

