

PLEASE PRINT

**UNIVERSITY OF PITTSBURGH MEDICAL CENTER
REQUEST FOR TRANSPLANT PATHOLOGY CONSULTATION**

Patient Information-Complete All Fields					
Last Name		First Name	M.I.	Social Security Number	
Street Address			City	State	Zip Code
Bill Submitting Institution _____ Bill Patient _____ Insurance information must be supplied if patient is to be billed			Birth Date	Sex	Phone (Including Area Code)
Insurance Carrier	Policy #	Group #	Name of Policy Holder and Relationship to patient		
Insurance Carrier Address		City	State		Zip Code

Collection/Reporting Information-Complete All Fields				
Requesting Pathologist: Last Name		First Name		
Pathologist Phone (Including Area Code)		Fax Number (Including Area Code)		
Institution Name		Institutional Account #		
Street Address		City	State	Zip Code
Date Specimen Collected	Institution Phone (Including Area Code)		Fax Number (Including Area Code)	
Copy to: Physician Name	Phone (Including Area Code)		Fax Number (Including Area Code)	

Clinical History _____

Pre-op Diagnosis _____ Post-op Diagnosis _____ Procedure _____

Specimen(s): Outside case #(s) _____

Special Instructions _____

<p>CHECKLIST OF ENCLOSURES</p> <p>_____ Surgical Accession Number</p> <p>_____ H&E glass slides(Total Number _____)</p> <p>_____ Unstained Slides (Total Number _____)</p> <p>_____ Special stains (Total Number _____)</p> <p>_____ Wet tissue (fixative/transport medium _____)For IF/EM _____</p> <p>_____ Surgical Pathology Report</p> <p>_____ Clinical information</p> <p>_____ Blocks (Total Number _____)</p>

All consultations should be mailed or sent by courier to:

**UPMC PRESBYTERIAN SHADYSIDE HOSPITAL
DEPARTMENT OF PATHOLOGY
DIVISION OF TRANSPLANTATION PATHOLOGY
ROOM E-733 MUH
MONTEFIORE HOSPITAL
3459 FIFTH AVENUE
PITTSBURGH, PA 15213
TELEPHONE: 412-647-7645
FAX: 412-647-5237
ATTN: JOYCE MARCOZ**