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Boston Children's Hospital

Where the world comes for answers

PATHOLOGY CONSULT REQUISITION

BCH PATHOLOGY LABEL

DEPARTMENT OF PATHOLOGY – Farley 190 - BCH3027
300 LONGWOOD AVENUE, BOSTON, MA 02115 | PHONE: 617-355-7431 | FAX: 617-730-0207
EMAIL: pathology@childrens.harvard.edu

Service Requested: ☐ **Anatomic Pathology Consultation** ☐ **Molecular Consultation**

PATIENT INFORMATION: **(PLEASE PRINT IN BLACK INK)**

LAST NAME	FIRST	MI

ADDRESS	CITY	STATE	ZIP

BIRTH DATE	SEX	PHONE	PATIENT ID #

REQUESTOR:

NAME

ADDRESS

PHONE

ORDERING PHYSICIAN CONTACT INFORMATION:

PHYSICIAN NAME

PHYSICIAN NPI (NON-BCH PROVIDERS) | PHYSICIAN PHONE

PHYSICIAN EMAIL

☐ Fax report to:

☐ Email report to: _____

Is this order for a clinical research study or trial *(select one)*: ☐ Yes or ☐ No

If YES, provide study name: _____

REQUESTOR SIGNATURE

BILL TO: ☐ Patient Insurance ☐ Requestor ☐ Patient Self-Pay *HMO Insurance Authorization #* _____

Charges for patients classified as a hospital "inpatient or "outpatient" at the requesting facility on the date of service must be billed to the requesting facility unless an appropriate exception applies. SSA §1833(h)(5)(A); SSA §1833(h)(5)(A)(iii); SSA §1861(w)(1); 42 §CFR 414.510

INSURANCE NAME

SUBSCRIBER LAST NAME	FIRST	MI	INSURANCE PHONE	BENEFICIARY/MEMBER #

CLAIMS ADDRESS (IF AVAILABLE)	CITY	STATE	ZIP	GROUP # (IF AVAILABLE)

FOR INSTITUTIONAL USE ONLY

PATIENT STATUS: ☐ Inpatient ☐ Outpatient ☐ Non-Hospital Patient Hospital Discharge Date: ____ ____ ____

With the exception of patient-initiated consults, you may be required to obtain a prior insurance authorization. Denied claims for any reason will be billed to the requestor.

ICD-10 Diagnosis Code Required: 1. _____ 2. _____ 3. _____

CLINICAL INFORMATION: ☐ See Attached Letter ☐ Copy of Pathology Report

A COPY OF THE PATHOLOGY REPORT IS REQUIRED. A SEPARATE PATHOLOGIST LETTER IS OPTIONAL.

ATTACH FILES

BRIEF CLINICAL HISTORY

SPECIMEN INFORMATION (ANATOMIC & MOLECULAR):

Collection Date: ____ ____ ____ Time: _____

BODY SITE	CLIENT CASE NUMBER(S)

☐ Blocks Qty: _____ ☐ Stained Slides Qty: _____ ☐ Unstained Slides Qty: _____ ☐ Other Qty: _____

MOLECULAR TEST MENU (PLEASE SELECT AT LEAST ONE)*: **Boston Children's Hospital, Department of Pathology, ATTN: LAMPP Lab, Bader 013, 300 Longwood Avenue, Boston, MA 02115**

☐ Solid and brain tumor fusion panel ☐ Heme malignancy fusion panel ☐ BRAF V600E ddPCR

☐ PIK3CA ddPCR *(select variants):* ☐ C420R ☐ E542K ☐ E545K ☐ H1047L ☐ H1047R ☐ All ☐ MYOD1 L122R ddPCR

☐ Nucleic acid extraction only *(specify type):* ☐ DNA ☐ RNA ☐ TNA

Sample Origin: ☐ Bone marrow ☐ Blood ☐ Tissue (Type: _____)

Sample Prep: ☐ Fresh ☐ Frozen ☐ Air dried ☐ Paraffin (Fixative: ☐ Formalin ☐ Other: _____)

Estimate of % tumor cellularity: _____ *Note: Acid decalcification and Bouin's fixative are not acceptable*

***Procedures include Professional Interpretation unless otherwise requested.** ☐ No Professional Interpretation

For Department Use Only:

DATE RECEIVED	ACCESSION #	RECEIVED BY

ADDITIONAL INFORMATION