

PLEASE PRINT

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



IF REQUIRED FIELDS ARE NOT PROVIDED, TESTING MAY BE DELAYED

Patient Information *Complete All Fields*

Last Name		First Name		M.I.	SSN
Street Address				City	State Zip
Bill Submitting Institution <input type="checkbox"/> Bill Patient* <input type="checkbox"/> <i>*Note: Insurance information must be supplied if patient is to be billed. If payment is denied by insurance, you will be responsible for payment for services. For Medicare patients classified as a hospital inpatient or outpatient on the date of service, charges must be billed to referring client.</i>				DOB	Sex Phone
Insurance Carrier	Policy #	Group #	Name of Policy Holder and relationship to patient		
Insurance Carrier Address		City	State	Zip	

Collection/Reporting Information *Complete all Fields*

Requesting Clinician: Last Name		First Name	
Clinician Phone #		Fax Number	
Copy to: Pathologist Name	Pathologist Phone:	Pathologist Fax:	
Institution Name & Address	Street	City	State Zip
Date Specimen Collected	Institution Phone #	Fax	

Clinical History: _____

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

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

Prepared slides (#)*: _____ Unstained Slides(#)**: _____ Adhesive Used: _____

*Recut slides preferred to allow for retention by UPMC Faculty. **Blocks are preferred.

Blocks (#) & Description: _____ Fixative: _____

Anatomic Pathology Consultation Request: *Must check one for testing to occur. Attach original pathology report from your institution!*

☒ Complete formal consultation: Designated Pathologist (optional; see reverse side): DR. RAJA SEETHALA

☐ FISH testing (see reverse) _____

☐ Immunoperoxidase stains only, no interpretation (mail to Presbyterian): _____

☐ Immunoperoxidase stains with interpretation (mail to Presbyterian): _____

☐ Special histochemical stains only (state individual stains; mail to Presbyterian): _____

☐ Special histochemical stains and interpretation (state individual stains; mail to Presbyterian): _____

☐ Other, specify: _____

☐ Molecular tests on solid tumors (See reverse side; mail to Presbyterian): _____

Physician Signature and Consent

Billing Disclaimer – All specialized testing is billed directly to the submitting institution. Tests sent to FISH/ISH Lab as well as molecular testing will be charged separately. If additional testing is being requested, a signed MSA is required from the submitting institution. Please review and complete MSA (pages 3-7) prior to submission.

My signature certifies that I have determined that the test(s) being ordered is medically necessary for the patient, certifies that the results of this test will inform the patient's ongoing treatment plan, and certifies that I am the patient's treating physician. I acknowledge that payment for any additional testing that is completed will be the responsibility of my institution if not covered by patient insurance.

Treating Physician Signature

Printed Name (Full Legal Name)

Date (MM/DD/YYYY)

All consultations should be mailed or sent by courier to (See below for pathologist location):

UPMC Presbyterian Hospital
Dept. of Pathology
Consultation Services
Room C606
200 Lothrop Street
Pittsburgh, PA 15213-2582
T: 412-647-8275
F: 412-647-0221

UPMC Shadyside Hospital
Dept. of Pathology
Consultation Services
Room WG02
5230 Centre Avenue
Pittsburgh, PA 15232
T: 412-623-2318
F: 412-682-6450

Magee-Womens Hospital of UPMC
Dept. of Pathology
Consultation Services
Room 4105
300 Halket Street
Pittsburgh, PA 15213
T: 412-641-4641
F: 412-641-6169

UPMC Montefiore Hospital
Dept. of Transplantation
Consultation Services
Attn: Selene Douglass
Room E-733
3459 Fifth Ave
Pittsburgh, PA 15213
T: 412-647-7645
F: 412-647-5237

UPMC St. Margaret
Dept. of Pathology
Consultation Services
815 Freeport Road
Pittsburgh, PA 15215
T: 412-784-4130
F: 412-784-4985

UPMC Clinical Lab Building
Division of Hematopathology
Consultation Services
9th Floor, Room 9032
3477 Euler Way
Pittsburgh, PA 15213
T: 412-864-6175
F: 412-864-1784

UPMC Presbyterian Hospital
Division of Neuropathology
Consultation Services
Room S701 Scaife Hall
3550 Terrace Street
Pittsburgh, PA 15261
T: 412-624-9415
F: 412-624-5610

Children's Hospital
4401 Penn Avenue
B260
Dept. of Pathology
Pittsburgh, PA 15224
T: 412-692-5650
F: 412-692-6550

AUTOPSY/INFECTIOUS PATHOLOGY

Tanner Bartholow, MD
UPMC Presbyterian: (412) 647-1470

BONE-SOFT TISSUE PATHOLOGY

Ivy John, MD
Rana Naous, MD
UPMC Shadyside: (412) 623-2318
Karen Schoedel, MD
UPMC Presbyterian: (412) 647-9575

BREAST/GYNECOLOGIC PATHOLOGY AND GYN- CYTOPATHOLOGY

Rohit Bhargava, MBBS
Gloria J. Carter, MD
Beth Clark, MD
Esther Elishaev, MD
Jeffrey Fine, MD
Lakshmi Harinath, MD
Mirka Jones, MD
Olga Navolotskaia, MD
Thing Rinda Soong, MD
Tatiana Villatoro, MD
Jing Yu, MD, PhD
Chengquan Zhao, MD
UPMC Magee: (412) 641-4641

CYTOPATHOLOGY- NON-GYNECOLOGICAL

Zarine Kamaluddin, MD
Samer Khader, MD
Sigfred Lajara, MD
Rana Naous, MD
UPMC Shadyside: (412) 623-3765
Sheldon Bastacky, MD
N. Paul Otori, MD
Lama Farhat, MD
Omid Savari, MD
Karen Schoedel, MD
UPMC Presbyterian: (412) 647-3478

DERMATOPATHOLOGY/IF

Jagjit Singh, MD
UPMC St. Margaret: (412) 784-4000

ENDOCRINE PATHOLOGY

Simion Chiosea, MD
Yuri Nikiforov, MD, PhD
Robert Peel, MD
Raja Seethala, MD
UPMC Presbyterian: (412) 647-9051

EYE PATHOLOGY

Charleen Chu, MD, PhD
UPMC Presbyterian: (412) 647-9417

FISH STUDIES

Daniel Marker, MD, PhD
Raja Seethala, MD
UPMC Presbyterian: (412) 647-9051

GENITOURINARY PATHOLOGY

Rajiv Dhir, MD
Gabriela Quiroga-Garza, MD
UPMC Shadyside: (412) 623-2318
Sheldon Bastacky, MD
UPMC Presbyterian: (412) 647-9612

GI PATHOLOGY

Ibrahim Abukhiran, MBBS
Phoenix Bell, MD
Jon Davison, MD
Lama Farhat, MD
Douglas Hartman, MD
Reetesh Pai, MD
Aatur Singhi, MD
UPMC Presbyterian: (412) 647-3720

HEAD AND NECK

Simion Chiosea, MD
Robert Peel, MD
Raja Seethala, MD
UPMC Presbyterian: (412) 647-3732

HEMATOPATHOLOGY

Nidhi Aggarwal, MD
Nathanael Bailey, MD
Grant Bullock, MD, PhD
Miroslav Djokic, MD
Sara Monaghan, MD
Erika Moore, MD
Bryan Rea, MD
Flavia G. Rosado, MD
UPMC Presbyterian: (412) 647-5191

INFORMATICS

Douglas Hartman, MD
UPMC Presbyterian: (412) 647-3732

KIDNEY/EM

Sheldon Bastacky, MD
UPMC Presbyterian: (412) 647-9612

LIVER, CARDIAC, AND TRANSPLANT PATHOLOGY

A. Jake Demetris, MD
Bassem Hendawy, MD
Nigar Khurram, MD
Marta Minervini, MD
Parmjeet Randhawa, MD
UPMC Presbyterian: (412) 647-7645

MALIGNANT MELANOMA

Jagjit Singh, MD
UPMC St. Margaret: (412) 784-4000
Karen Schoedel, MD
UPMC Presbyterian: (412) 647-9575

NEUROPATHOLOGY

Julia Kofler, MD
Scott Kulich, MD, PhD
Daniel Marker, MD, PhD
Thomas Pearce, MD, PhD
Clayton Wiley, MD, PhD
UPMC Presbyterian: (412) 647-9415

PERINATAL PATHOLOGY

Stefan Kostadinov, MD
Lauren Skvarca, MD
UPMC Magee: (412) 641-3708

PULMONARY AND MEDIASTINAL PATHOLOGY

Brittany Cody, DO
N. Paul Otori, MD
Omid Savari, MD
UPMC Presbyterian: (412) 647-6193

TUMOR CYTOGENETICS

UPMC Magee: (412) 641-4267

THORACIC PATHOLOGY

N. Paul Otori, MD
Gabriel Sica, MD
UPMC Presbyterian: (412) 647-9843

**UPMC Presbyterian Shadyside
Clinical Laboratory Services Agreement**

This LABORATORY SERVICES AGREEMENT (“Agreement”) is dated this ____ day of _____, 2022 (the “Effective Date”) by and between UPMC Presbyterian Shadyside, a nonprofit tax exempt Pennsylvania corporation, having a principal place of business at 200 Lothrop Street, Pittsburgh, PA 15213, acting in collaboration with affiliate University of Pittsburgh Physicians Department of Pathology, and the UPMC XXXX Laboratory “XXXX”, collectively hereinafter “UPMC “and “XXXX”, and _____ (“Facility”).

In consideration of the mutual covenants set forth herein, intending to be legally bound hereby, and for other good and valuable consideration, the parties hereto agree as follows:

1. **Services.** XXXX agrees to provide Services for Facility on an as-requested in writing basis and in accordance with all applicable federal, state and local laws, rules and regulations, as well as any applicable UPMC policies. Services shall include, but are not limited to, the tests and services as noted on and selected by Facility from the XXXX website (www.XXXXXX.upmc.com) as performed on patient samples (properly obtained with consent by Facility) to provide information for the diagnosis, prevention or treatment of a disease or medical condition. This Agreement may encompass payment of reference lab services previously provided at XXXX, where XXXX at the time of the services rendered was acting as a contract lab for Facility.

All such tests shall be conducted on a quality, professional basis consistent with applicable industry standards. XXXX and its employees shall maintain all required licenses. XXXX shall maintain current Clinical Laboratory Improvement Amendments (CLIA) accreditation. XXXX will also hold accreditation from the Pennsylvania Department of Health (PA DOH).

2. **Fees.** For Services rendered hereunder, Facility agrees to reimburse XXXX at the rate(s) acknowledged by Facility at the time of executing this agreement. Current test pricing must be obtained by contacting the UPMC XXXX Laboratory at 1-844-XXXX prior to executing this agreement. No tests or services will be priced or offered below the fair market value. XXXX will bill Facility via mailed invoice. XXXX invoices are due and payable by Facility forty-five (45) days after receipt. All payments shall be remitted to UPMC at the following address:

UPMC Presbyterian Shadyside
P.O. Box 382007
Pittsburgh, PA 15250-8007

The Agreement begins on the date noted above (the “Effective Date”) and continues until the full negotiated agreed payment in Exhibit B is received by XXXX.

3. **Service Orders.** Every specimen must be sent to the laboratory consistent with industry standards, commercial carriers, and with the appropriate test requisition form, and billing contact information. Information regarding the availability of requisition forms and specimen handling instructions may be obtained by contacting the UPMC XXXX Laboratory at 1-844-XXXX or by visiting www.XXXXXX.upmc.com.
4. **XXXX Responsibilities.** XXXX will be available to accept delivery of Samples to be tested at XXXX's designated receiving office between the hours of 9:00 a.m. and 5:00 p.m., Monday through Friday. Upon completion of the Services, XXXX will send a final report ("Report") to Facility via facsimile. Report will include at least the following: patient name, date of birth, date of collection, accession number, date of report(s), and name of test, test result, an interpretation of the result, and laboratory name and address. Depending on the specific test selected by Facility, the turnaround time can range from 7 business days to 14 business days.
5. **Facility Responsibilities.** Facility will deliver patient specimen material to be tested ("Material") to XXXX's designated receiving laboratory between the hours of 9:00 a.m. and 5:00 p.m., Monday through Friday, in a manner in compliance with UPMC's requirements and applicable legal requirements for such transport, as amended from time to time. As between the Parties, Facility is solely responsible for transporting Materials between the Parties and protecting against any unauthorized disclosures of protected health information while the Material is in transit (regardless of whether transfer mode is electronic or otherwise).
6. **Facility's Patient Care Responsibilities.** Nothing in this Agreement shall relieve the Facility of its responsibilities for the care of its patients, including Facility's use of test results or any other information provided to Facility by XXXX pertaining to the Services. UPMC/ XXXX has no responsibility or liability whatsoever for the above.
7. **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania without regard to its conflicts of laws principles. This Agreement is the entire agreement between the Parties and supersedes any other oral or written communications, proposals, quotes, advertisements, or understandings regarding the subject matter hereof. This Agreement may be amended only in writing, and only if signed prospectively by both authorized representatives of both Parties.

Facility agrees to and has executed this Agreement effective on the day and in the year first set forth above.

Dated: _____

FACILITY

By: _____

Name and title of authorized signatory

EXHIBIT A1

Services – XXXX

Description of Services	
Description of services:	UPMC will perform tests (selected from Exhibit B1 Lab Service Charge Schedule – XXXX) as requested by Facility as selected from schedule of services listed at www.XXXX.upmc.com; samples will be processed and sequenced in the UPMC XXXX lab.
Materials & Delivery (incl. quantity):	<p>Samples should be shipped to XXXX at the following address:</p> <p>UPMC Department of Pathology Gross Lab- Room A613 200 Lothrop Street Pittsburgh, PA 15213 USA</p> <p>All shipping costs are the responsibility of the requesting facility.</p> <p>UPMC will be available to accept delivery of Samples to be tested at UPMC's designated receiving office between the hours of 9:00 a.m. and 4:00 p.m., Monday through Friday in a manner in compliance with UPMC's requirements and applicable legal requirements for such transport, as amended from time to time.</p> <p>Specimens arriving after routine working hours will be held until the next business day.</p>
Test Orders, Results and Delivery Times:	<p>XXXX requires a completed paper requisition with patient demographics, requesting physician information, requesting institution information, and test ordered.</p> <ul style="list-style-type: none">• A cytology, endoscopy or surgical pathology report must accompany all specimens <p>Email notification to AP_StatBX@upmc.edu is required prior to shipment of specimen.</p> <p>Samples arriving without an accompanying requisition will be held until receipt of the requisition.</p> <p>All specimens will be tested according to the agreed upon protocols.</p> <p>Final results will be faxed to the ordering physician listed on the requisition and to the requesting institution Department of Pathology.</p>
Additional Requirements (if any):	Not applicable

Customer Contacts:	<u>Operational Contact:</u> <u>To Be Provided:</u>	<u>Business/Administrative Contact:</u> To be Provided:
UPMC Contacts:	<u>Operational Contact:</u> TBD	<u>Business/Administrative Contact:</u> Kathleen Cieply, Director, Anatomic Pathology Clinical Labs Building Room 9019 3477 Euler Way Pittsburgh, PA 15213 412-647-3934 cieplykm@upmc.edu

EXHIBIT B1

Lab Service Charge Schedule

Compensation and Payment	
Test Rendered	Total Fee
ADD DETAILS HERE	
For test that are offered by UPMC Presbyterian Shadyside Clinical Laboratory but are not defined within this exhibit, the standard rate of hospital charge minus 20% discount would apply	
Invoicing/Payment Schedule:	<p>Payment shall be made in accordance with the terms of this Agreement.</p> <p>All invoices shall be submitted via paper to the Facility.</p> <ul style="list-style-type: none">• Invoice date (date of issue)• Invoice number• Date, description and quantity of services• Invoice amount and currency in U.S. Dollars <p>UPMC and facility will agree on terms of payment – ACH, Wire, Check.</p>