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_____

_____

CHECKLIST OF ENCLOSURES

_____ **Surgical Accession Number**

____H&E glass slides(Total Number_____)

____Unstained Slides (Total Number_____)

____Special stains (Total Number_____)

____Wet tissue (fixative/transport medium_____)For IF/EM____

____Surgical Pathology Report

____Clinical information

____Blocks (Total Number_____)

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: Selene Douglass