

**PATHOLOGY CONSULTS**

Thank you for considering Northwestern Medicine at Northwestern Memorial Hospital for your pathology consult needs.

Please have the following requirements available to complete the checklist:

- 1) Patient full name
- 2) Patient Clinical Information
- 3) Patient insurance information
- 4) Copy of insurance card
- 5) Number of slides and/or blocks
- 6) Accession or case number from the originating/requesting institution
- 7) Pathology reports from the originating/requesting institution
- 8) Mailing address for slides and/or blocks return

Important contact information:

- Pathology consult staff: 312-926-1267
- Manager, Ricardo Sumugod: rsumugod@nm.org or 312-926-8446
- Address for delivery via Courier or FedEx:
Central Specimen Receiving
251 East Huron Street
Feinberg 7-307
Chicago, IL 60611
- NM Regional Hospitals Consult – please find the FedEx delivery address on the checklist found this link: <https://nmi.nmh.org/wcs/page/nmh-path-labs-consult-second-opinion>

Complete the checklist below, and include it with the slides/blocks when sending to NM Pathology Consults.

1) **Is the patient diagnosis pending?:** Yes, Pending Diagnosis No, Diagnosis Code: _____
Patient's Clinical Information: _____

2) **Type of Consult, please check what applies:** Surgical Neuro Cytopathology Hematopathology
 Dermatopathology – Separate Service – Please contact the Department of Dermatology at 312-695-8106

Specimen Date	Case Number	# of Stained Slides	# of Unstained Slides	# of Blocks	Description of Specimen/Report

3) **Patient information:**

Full Name:		Cellphone:	
Date of Birth:			
Mailing address:			
City, State, Zip Code:			
Insurance Information:			

4) **Consult requested by:** Return materials back to requesting institution address below

Clinician Full Name:		Phone/Pager Number:	
	<input type="checkbox"/> Request to be contacted when accessioned		
Pathologist Full Name:		Phone/Pager Number:	
	<input type="checkbox"/> Request to be contacted when accessioned		
Institution:			
Mailing address:			
City, State, Zip Code:			
Patient Full Name:		Cellphone:	

5) **If sending fresh tissue, please email NMHPATHOUTSIDECONSULTS@nm.org with the following information:**

Specimen Type :			
Fixative :			
Test Requested :			
TAT Expectation:	<input type="checkbox"/> Routine (6 business days)	<input type="checkbox"/> STAT (2 business days)	
Specimen Previously Grossly Examined?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

6) **Billing information: who is responsible for the bill**

Patient (Self-Pay): _____ Requesting Institution: _____
 Patient Insurance: _____ Requesting Physician: _____

Lab Use Only					
Received By:		Date:		Time:	