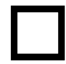
Northwestern Medicine®

 **STAT** **PATHOLOGY CONSULTS**

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

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☐ **STAT** **PATHOLOGY CONSULTS**

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:	
		☐Request to be contacted when accessioned	
Pathologist Full Name:		Phone/Pager Number:	
Institution:		☐Request to be contacted when accessioned	
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:	☐Routine (6 business days)	☐STAT (2 business days)
Specimen Previously Grossly Examined?	☐Yes	☐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:	

https://www.nm.org/conditions-and-care-areas/lab-services/department-of-pathology/forms