WashU Medicine

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CONSULT REQUEST

DATE

LAB USE ONLY

Accession Number

Date Received:

Accessioner:

ORDERING PROVIDER - PLEASE SIGN AT THE BOTTOM

Name:	Institution:
Address:	
Phone:	Fax:
Copy to Provider/Institution A:	Fax:
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PATIENT INFORMATION - PLEASE ATTACH COPY OF INSURANCE CARD/DEMOGRAPHIC SHEET

Last Name:	First Name:	Middle Name:
DOB:	Race:	Sex: ☐ M ☐ F

OUTSIDE ACCESSION#	Number of SLIDES	Number of BLOCKS	ANATOMICAL SITE	CLINICAL DESCRIPTION
A)				
B)				
C)				
D)				

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PATHOLOGICAL DIAGNOSIS

CONSULT REQUEST

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