



April 1, 2011

Dear referring facility:

Attached please find our revised consult request form. All requests for consultation will require the attached request form along with billing information and patient medical history. Also attached is our fee schedule for consultations that will go into effect starting April 15, 2011.

We value your relationship and are available for any questions or inquiries. Please feel free to contact Catherine Nakasone, Laboratory Outreach Manager, or Dr. Paul Pattengale, Medical Director Outreach Services at the numbers below.

Catherine Nakasone  
cnakasone@chla.usc.edu  
323-361-4928

Dr. Paul Pattengale  
ppattengale@chla.usc.edu  
323-361-5608

Sincerely yours,

A handwritten signature in black ink, appearing to read "A R Judkins", with a long horizontal flourish extending to the right.

**Alexander R. Judkins, MD, Pathologist-in-Chief**  
Department of Pathology and Laboratory Medicine  
Children's Hospital Los Angeles



ALEXANDER R. JUDKINS, M.D., PATHOLOGIST IN CHIEF  
Children's Hospital Los Angeles Laboratory  
4650 Sunset Blvd., MS 43 | Los Angeles, CA 90027  
Phone: (323) 361-2469; Fax: (323) 361-8004

**Consultation Request Form**

CHLA Acc #: \_\_\_\_\_

Facility: \_\_\_\_\_ Date: \_\_\_\_\_

Ordering Physician Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

**The information in this section is mandatory for patient tracking. Missing information could delay review of the case.**

Pt. First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M / F \_\_\_\_\_ S.S. #: \_\_\_\_\_

Materials Submitted: (PLEASE INCLUDE COPY OF PATHOLOGY REPORT)

Slides: Path #: \_\_\_\_\_ No.: \_\_\_\_\_ Blocks: Path #: \_\_\_\_\_ No.: \_\_\_\_\_

Slides: Path #: \_\_\_\_\_ No.: \_\_\_\_\_ Blocks: Path #: \_\_\_\_\_ No.: \_\_\_\_\_

Other: \_\_\_\_\_ Collection Date: \_\_\_\_\_

**BILLING INFORMATION- REQUIRED**

**Send bill for this consult to: (Please check one and provide all the information requested.) Cases submitted without patient insurance information will be billed to the referring physician/pathologist or alternatively can be charged against a credit card account. We regret we cannot bill Medicaid outside of CA.**

Referring pathologist/facility: \_\_\_\_\_

Clinician (Name, address, phone number): \_\_\_\_\_

Patient Insurance – Please attach facesheet or CHLA Billing Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insurance: \_\_\_\_\_ **(Please provide copy of front/back of insurance card.)**

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_ Referring Pathologist UPIN #: \_\_\_\_\_

Use one form per case. Enclose a cover letter outlining the clinical history and a copy of the surgical pathology report, even if incomplete (gross description of specimen), to document patient identity as well as slide labeling.

**Children's Hospital Los Angeles; Department  
of Pathology and Laboratory Medicine  
Updated Consult Fee Schedule  
Effective April 15th, 2011**

<b>CPT</b>	<b>Description</b>	<b>Price</b>
88300	Surgical path, gross	\$80.00
88302	Tissue exam by pathologist	\$160.00
88304	Tissue exam by pathologist	\$187.00
88305	Tissue exam by pathologist	\$311.00
88307	Tissue exam by pathologist	\$664.00
88309	Tissue exam by pathologist	\$998.00
88312	Special stains group 1	\$317.00
88313	Special stains group 2	\$233.00
88321	CONSULT REF SLIDES.	\$248.00
88323	Microslide consultation	\$405.00
88325	CONSULT COMPREHENSIVE.	\$565.00
88342	Immunohistochemistry	\$303.00
88348	Electron microscopy	\$2,049.00