Children's Hospital Los Angeles
Department of Pathology and Laboratory Medicine
4650 Sunset Blvd., MS 43 | Los Angeles, CA 90027
Phone: (323) 361-2426; Fax: (323) 361-8004

CHLA Internal Case # _____

CONSULTATION REQUEST FORM

Please use one form per case to include:
1) cover letter containing a summary of the clinical history and 2) a copy of the surgical pathology report, even if incomplete

Referring Facility: _____ Date: _____

Ordering Physician Name: _____ Signature: _____

Phone: _____ Fax: _____

Address: _____

Contact Name:_____Phone: _____ Email: _____

MATERIAL SUBMITTED

The information in this section is mandatory. Missing information could delay review of the case.

Patient's First Name: _____Last Name: _____

Age: _____ DOB: _____ Sex: M / F _____ MRN #: _____

Path #: _____ #Blocks_____ #Slides: _____ Collection Date: _____

BILLING INFORMATION (Required)

*****Please note at this time we are not able to bill the patient's insurance directly for any services we provide*****

SEND INVOICE TO:

Billing Contact Person: _____

Institution/Facility: _____

Address: _____

_____

Phone: _____ Fax: _____ E-mail: _____

Ship slides in secure slide holders and padded envelopes, or ship paraffin blocks. Please send all materials to:

Children's Hospital Los Angeles
Department of Pathology and Laboratory Medicine
4650 Sunset Blvd., MS #43
Los Angeles, CA 90027

Revised 11/19/14