

**WEILL CORNELL MEDICAL COLLEGE
COMPREHENSIVE DERMATOPATHOLOGY SERVICE
CYNTHIA M. MAGRO, MD, DIRECTOR
1300 York Avenue New York, New York 10065
Phone (212) 746-6434 Fax (212) 746-8570**

REQUEST FOR CONSULTATION

Referring Physician _____
Street Address _____
City/State/Zip _____

Date _____
Phone () _____
Fax () _____

PATIENT INFORMATION AND HISTORY

Patient Name _____ Age _____ DOB _____ Gender M / F (Circle one)
Home Address _____ City/State/Zip _____
*Site of Biopsy(s) _____
*ICD-9 Diagnosis _____
*Reason for Consultation _____

**This information may be included in a covering letter to Dr. Cynthia Magro.*

MATERIALS SUBMITTED

Slides: Path #: _____ No.: _____ Blocks: Path #: _____ No.: _____
Slides: Path #: _____ No.: _____ Blocks: Path #: _____ No.: _____

BILLING INSTRUCTIONS: You must select one

Send bill to: Referring Physician
Clinician (Name and address)

Patient Name: _____
Address _____
Phone () _____
Insurance Co. Name/Address/Phone _____

Policy No. _____

Other _____

Please include a copy of the patient insurance card (front/back)

Kindly provide a copy of the Surgical Pathology report and package with slide protection. Thank you