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 _____ Date _____
Street Address _____ Phone ( ) _____
City/State/Zip _____ Fax ( ) _____

PATIENT INFORMATION AND HISTORY

Patient Name _____ Age _____ DOB _____ Gender M / F (Circle one) ☐ ☐
Home Address _____ City/Sate/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)
_____
_____
_____

☐ Other _____

☐ Patient Name: _____
Address _____
Phone ( ) _____
Insurance Co. Name/Address/Phone
_____
_____
Policy No. _____

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