BEACON PATHOLOGY

Director and Consultant: Alireza Sepehr, MD

Dermatopathology Consultation Request

Patient Name: _____ DOB: _____

Patient's Medical Insurance Information Attached: Yes____ No____

Date Requested: _____ Date of Procedure:_____

Pathology Accession Number:

Biopsy Site: _____ Encloses Slide(s):_____ Enclosed Block(s):_____
Biopsy Site: _____ Encloses Slide(s):_____ Enclosed Block(s):_____
Biopsy Site: _____ Encloses Slide(s):_____ Enclosed Block(s):_____
Biopsy Site: _____ Encloses Slide(s):_____ Enclosed Block(s):_____

Requesting Physician:_____
Address: _____
_____
City:_____ State:___ Zip Code:_____
Phone:_____
Fax:_____

Clinical Information: _____
_____

PLEASE SEND THIS SHEET TO THE FOLLOWING ADDRESS WITH:

A) THE PATIENT'S INSURANCE INFORMATION
B) SLIDE(S) AND TISSUE BLOCK(S)

Beacon Pathology
Attn: Alireza Sepehr, MD
35 Brookfield Rd
Dover, MA 02030

P: 508-785-1076
Email: beaconpathology@gmail.com