AMYLOID PATHOLOGY CONSULTATION FORM

Amyloidosis Center
Gerry Amyloid Research Laboratory
Boston University School of Medicine
72 East Concord Street, K503
Boston, MA 02118
617/638-4317 (Phone); 617/638-4493 (Fax)

Patient Name (Last, First, MI):

____ **Date:** __________

Date of Birth: _____________ **Sex: M F** **MRN#:** _______________

Patient Address (Please include City, State, Zip Code and Phone Number):

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SEND REPORT TO:

Name: ______________________________

Address: ______________________________

Phone and Fax ______________________________

I Understand That There Is a Fee Associated With This Testing: ___________________________
Signature

SPECIMEN TYPE: ________________________ **TESTING REQUESTED:** __________________

DATE OF SPECIMEN COLLECTION: ____________________

CLINICAL DIAGNOSIS/HISTORY:____

INSURANCE COVERAGE

Carrier: _______________________________ **Policy Number:** ___________________

Group Name: ___________________________ **Group Number:** ___________________

Subscriber: ____________________________ **Relationship:** ______________________

FOR OFFICE USE ONLY

❑ 1. There is NO amyloid detected with a Congo red stain.

❑ 2. There is POSITIVE Congo red stain consistent with amyloid (   ).

Attending: Dr. John Berk **Specimen Rec'd Date:**__________