



AMYLOID PATHOLOGY CONSULTATION FORM



**Amyloidosis Center
Gerry Amyloid Research Laboratory
Boston University School of Medicine
72 East Concord Street, K503
Boston, MA 02118
617-358-4750 (Phone); 617-358-4735 (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):

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:** _____