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SURGICAL PATHOLOGY REQUEST FORM

Name:

AGE:

Address:

DOB

SEX

Insurance:

Private consultation:

Date of operation:

Surgeon:

Send Report to:

Clinical History:

Infectious precautions	Yes	No	Specify
Request previous diagnosis correlation	Yes	No	
Previous biopsy	Yes	No	Unknown
Previous chemotherapy	Yes	No	Unknown

Pre-operative diagnosis and differential:

Post-Operative Diagnosis:

Specific Questions to be answered by Consultation (if any):

Operation:

Tissue submitted:

This form completed by: _____ for: _____ M.D.

Signature: _____

DO NOT USE DANGEROUS ABBRIVIATIONS