LABORATORY AND PATHOLOGY SERVICES

ANATOMIC PATHOLOGY REQUEST FORM

(Complete Areas Not in Gray Only)

Carle

611 West Park Street
Urbana, IL 61801

1.

Date:_____ Performing #:_____ Requesting #:_____ Origin Dept:_____

MRN #:_____ Name:_____

Date of Birth:_____/_____/_____

Age:_____ Sex :_____

A #:_____ Room #:_____

2. Additional Copies to:_____

3. Pertinent History:

4. History of Malignancy? ☐ Yes ☐ No

If yes, site:_____

5. Immunosuppressed? ☐ Yes ☐ No

6. Preoperative Diagnosis:

7. Postoperative Diagnosis:

8. FIXATION TIME LOG

Time collected:

Time placed in fixative:

LAB USE ONLY

End fixation time:

Total fixation time:

9. Specimen Site, Source, Procedure (ex. right breast core; shave biopsy, left leg)

* Please be as specific as possible
* Do NOT use abbreviations – please write the entire word

A._____

B._____

C._____

D._____

E._____

F._____

G._____

* If more space is needed, please attach 2nd form and label accordingly.

10. Signing below verifies (1) specimen(s) is/are in jar and (2) each jar is labeled with patient 1st and last name, MRN #, specimen source

Verified by Physician/Performing Provider:_____ **(signature)** **Date:**_____ **Time:**_____

Second Verification Initials:_____ **Badge Number:**_____ **Phone Number:**_____

PATHOLOGIST NOTES:

☐ Frozen Section Submitted

Patient Name and Specimen Site Confirmed ☐

Frozen Section Interpretation Turn-Around Time Within 20 Minutes ☐