OHSU

Oregon Health & Science University
Hospitals and Clinics

ACCOUNT NO.

MED. REC. NO.

NAME

BIRTHDATE

Stamp Patient Card Here

DEPARTMENT OF PATHOLOGY
Pathologists Consultation
Report of Gross and Microscopic Examination

Requesting Physician Name	I.D. NUMBER	ACCESSION NO.	DATE OF SERVICE	REQ LOC	MAIL CODE

JCAHO REQUIRES COMPLETE INFORMATION

Date Specimen Received_____ **Hormonal Therapy**_____ **LMP**_____ **G**___**P**___**A**___

Known or Suspected: _____**AIDS** _____**Hepatitis**

_____**TB** _____**Other**

JCAHO Required **Clinical History / Pertinent Findings**_____

_____

_____

_____

HIPAA Required Data:

Date of current onset _____

Date of similar symptom _____

If Pregnant Y / N **LMP**_____ **estimated due date**_____

SPECIMENS SUBMITTED:

1) _____ **6)** _____

2) _____ **7)** _____

3) _____ **8)** _____

4) _____ **9)** _____

5) _____ **10)** _____

Physician's Signature _____ **Pager**_____