OHSU Health
Hospitals and Clinics
Department Of Pathology

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

SURGICAL PATHOLOGY DOWNTIME REQUISITION

REQUESTING PHYSICIAN NAME	LOCATION	DATE	TIME
FOR LAB USE ONLY	PHYSICIAN ID #	ACCESSION#	

REQUIRED INFORMATION

Date Specimen Received _____ Hormonal Therapy _____ LMP _____ G____ P____ A____

Known or Suspected: _____ AIDS _____ Hepatitis

_____ TB _____ Other

Clinical History/Pertinent Findings: _____

_____

_____

Circulating RN Name(s) _____ _____ _____ _____

Specimen	Time Tissue Removed From Patient	*Disposition	FS Transport Date/Time
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			

***Disposition:** Frozen Section = **FS** Standard = **STAN** ☐ Products of conception special request = **SPEC**

Results will be immediately available to the patient unless you mark the box below:

□ Do not release (I reasonably believe that an Information Blocking exception applies)

Required: Physician's Signature: _____ Date/Time _____