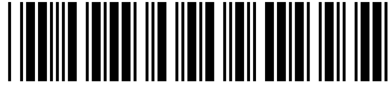
Oregon Health & Science University
Hospitals and Clinics
Department Of Pathology

DP2208



PATHOLOGISTS CONSULTATION REQUEST FOR GROSS AND MICROSCOPIC EXAMINATION

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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: ____

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____

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**

Required: Physician's Signature: ______________________________ Date/Time ______________

Original – Medical Records **Yellow Copy** – Send with Specimen **Pink Copy** – Place in Specimen Log Book