REQUEST FOR SURGICAL PATHOLOGY AND/OR NON-GYN CYTOLOGY

ANATOMIC PATHOLOGY LABORATORY
PHONE: (302) 645-3240 FAX: (302) 645-3197

Pathology Use Only

Patient Last Name: ____________________
First Name/Middle Initial: ______________
____
Date of Birth: ________________________
or Patient Identification Label, *if available*

Procedure Date:	**Procedure Location:**	**Ext.#:**
Procedure:		
Relevant Operative/Clinical Information (Required)		

Specimen Submitted/Anatomical Site (including laterality) **INSTRUCTIONS FOR DEVITALIZED (COLLECTION) TIME/TIME IN FORMALIN:** Devitalized (Collection) Time is the time tissue specimen is removed from the patient's body. Time in formalin is the time the specimen is actually placed in formalin. Amount of formalin to be added is 10-15 times the size of the specimen.	**Devitalized (Collection) Time hh:mm**	**Time Placed in Formalin hh:mm**	**FROZEN**	**FRESH**	**MICRO**	**MAMMO**	**CYTO**	**OTHER**
A.								
B.								
C.								
D.								
E.								
F.								
G.								
H.								
I.								
J.								
K.								
L.								

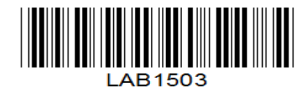
Performed by (or Designee)/Circulator Signature: ______________________ Date: __________ Time: __________

Copy of report to: ____

NOTE: Tissue for culture, flow cytometry, frozen section diagnosis, immunofluorescence, cytogenetics, etc must be sent FRESH; otherwise the specimen cannot be used for special testing.

Special Instructions:

Frozen Section Diagnosis: ***For Pathologist Use Only***
Pathologist's Signature: ______________________ Date: __________ Time: __________



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