The following information is needed for adequate evaluation, otherwise there may be an unnecessary delay.

PROCEDURE:

BRIEF HISTORY, DURATION, ASSOCIATED LESIONS, PRIOR SURGERY

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<tr>
<th>PHYSICIAN PERFORMING PROCEDURE</th>
<th>TELEPHONE AND/OR PAGER NO.</th>
<th>O.R. ROOM NO./CLINIC</th>
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PRE-OPERATIVE DIAGNOSIS: SPECIMEN NEEDS TO BE CULTURED?
- YES
- NO

POST-OPERATIVE DIAGNOSIS:

DIFFERENTIAL DIAGNOSIS:

ATTACH APPROPRIATE FORMS AND LIST SUSPECTED PATHOGENS:
- AEROBIC
- ANAEROBIC
- FUNGAL
- MYCOBACTERIA
- VIRAL (Specify):

CHECK MARGINS OF RESECTIONS?
- YES
- NO

SPECIAL REQUESTS (e.g., electron microscopy, fluorescence, etc.)

IDENTIFICATION OF SPECIMEN(S)

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<tr>
<th>TIME</th>
<th>TYPE OF TISSUE OR FLUID</th>
<th>LOCATION</th>
<th>BIOPSY OR EXCISION</th>
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SEND ADDITIONAL COPY OF REPORT TO:

PERSON FILLING OUT FORM (Please Print) PHONE NO.