Children's
Hospital of Pittsburgh

PATHOLOGY DEPARTMENT

SURGICAL PATHOLOGY CONSULTATION REQUISITION

Form No. 221 (9/04)

DATE Mo. / Day / Yr.

LAB No.

E.M. No.

1. Adm. #, Loc., MR #
2. Patient Name
3. Birthdate
4. Physician
5. Guarantor's Address
6. Guarantor
7. Phone #

ADDRESSOGRAPH / TYPEWRITTEN PATIENT IDENTIFICATION

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

PROCEDURE:

BRIEF HISTORY, DURATION, ASSOCIATED LESIONS, PRIOR SURGERY

PHYSICIAN PERFORMING PROCEDURE

TELEPHONE AND/OR PAGER NO.

O.R. ROOM NO./CLINIC

PRE-OPERATIVE DIAGNOSIS:

POST-OPERATIVE DIAGNOSIS:

DIFFERENTIAL DIAGNOSIS:

CHECK MARGINS OF RESECTIONS? ☐ YES ☐ NO

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

SPECIMEN NEEDS TO BE CULTURED?

☐ YES ☐ NO

IF YES, DO **NOT** FIX.

ATTACH APPROPRIATE FORMS AND LIST SUSPECTED PATHOGENS:

☐ AEROBIC ☐ ANAEROBIC

☐ FUNGAL ☐ MYCOBACTERIA

☐ VIRAL (Specify): ______

______

______

IDENTIFICATION OF SPECIMEN(S)

	TIME	TYPE OF TISSUE OR FLUID	LOCATION RIGHT OR LEFT	BIOPSY OR EXCISION
1				
2				
3				
4				
5				

SEND ADDITIONAL COPY OF REPORT TO:

PERSON FILLING OUT FORM (Please Print) PHONE NO.